Supreme Court, U.S.
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No. _____ OFFICE OF THE CLERK

In The

Supreme Court of the United States

October Term, 1996

VALERIE MILLER and VICKIE WILLIAMS, D.O.,

Petitioners,

vs.

ARLENE M. BROWN, M.D., and
FAMILY PRACTICE ASSOCIATES, P.C.,

Respondents.

**On Petition For Writ Of Certiorari
To The United States Court Of Appeals
For The Tenth Circuit**

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

The Health Care Quality Improvement Act protects participants in medical peer review activities from liability for damages resulting from review actions taken in the reasonable belief that the action was in the furtherance of quality health care, after a reasonable effort to obtain the facts, and in the reasonable belief that the action was warranted by the facts. The Act also protects individuals from liability for reporting medical peer review actions to a national data bank unless the report was knowingly false.

1. Should the "reasonableness" criteria for immunity under the Act be governed by an objective standard, so that a grant of immunity as a matter of law cannot be defeated by evidence that medical experts disagree as to whether a hospital's decision to revoke a physician's medical staff privileges was reasonable in particular circumstances?

2. Should the standard for immunity under the Act for reporting a review action be satisfied as a matter of law where the hospital's report that the physician's privileges were revoked based on "incompetence/malpractice/negligence" is accurate within the ordinary meaning of the language used?

PARTIES TO THE PROCEEDING

Respondents listed in the caption to this Petition were the sole plaintiffs below. Defendants below included the Petitioners listed in the caption and also included Presbyterian Healthcare Services, Gary Jackson, D.O., and Sierra Blanca Medical Associates, P.A. Presbyterian Healthcare Services has elected not to challenge the judgment against it, which involves a separate claim that does not involve the issues raised in this Petition, and hence it is not a party to this proceeding. Dr. Jackson and Sierra Blanca obtained favorable judgments which were not challenged on appeal, and hence they are not parties to this proceeding.

RULE 29.6 LISTING

Because Presbyterian Healthcare Services is not a party to this proceeding, a Rule 29.6 listing may not be necessary. However, Presbyterian Healthcare Services has publicly announced its intention to indemnify Petitioners if the judgments for damages against them are upheld. The following statement is presented in the event the Court determines that the concerns addressed by Rule 29.6 are implicated by this situation.

Presbyterian Healthcare Services is a New Mexico nonprofit corporation. It has no parent corporation. It has the power to appoint the boards of directors of Presbyterian Healthcare Foundation (a New Mexico nonprofit corporation without members), Southwest Health Foundation (a New Mexico nonprofit corporation whose sole member is Presbyterian Healthcare Services), and Presbyterian Properties, Inc. (a New Mexico nonprofit corporation whose sole member is Presbyterian Healthcare Services). None of these entities, or their affiliates, issues shares to the public.

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PETITION FOR WRIT OF CERTIORARI

Valerie Miller and Vickie Williams, D.O., respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Tenth Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App. A) is reported at 101 F.3d 1324. The relevant opinions of the district court (App. B & C) are unreported.

JURISDICTION

The court of appeals entered its judgment on November 29, 1996. (App. A.) The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

Pertinent provisions of the Health Care Quality Improvement Act, 42 U.S.C. §§ 11101-11152, are set forth in full in Appendix D.

STATEMENT OF THE CASE

This case concerns the standard that must be met to establish the limited immunity from damages granted by the Health Care Quality Improvement Act, 42 U.S.C.

§ 11101-11152 ("HCQIA"), to hospital administrators and physicians who, as a result of their involvement in hospital peer review activities, face suits for violation of the federal antitrust laws or other claims asserted by a physician whose medical staff privileges have been restricted. Despite the holdings of four other circuit courts that the HCQIA imposes an objective reasonableness standard to determine whether immunity is available to peer review participants who act in the name of patient safety, and despite evidence establishing that reasonable physicians could have reached the conclusions that were reached by the reviewers in this case, the Tenth Circuit held that a jury question was created by the testimony of another physician that he personally disagreed with the reviewers' decision. Consequently, the Tenth Circuit upheld a judgment on a jury verdict awarding treble antitrust damages against Petitioners.

In addition, the Tenth Circuit held that a jury could find that the hospital's report of its action to the National Practitioner Data Bank, as required by the HCQIA, was false and therefore not entitled to statutory immunity, despite the fact that the report was accurate within the ordinary meaning of the words used. Consequently, the Tenth Circuit upheld a judgment on a jury verdict awarding compensatory and punitive damages for defamation against one Petitioner.

The decision of the Tenth Circuit is in conflict with every other Circuit that has addressed the standard for HCQIA immunity and frustrates the purpose Congress sought to achieve through the HCQIA in the important areas of health policy, antitrust, and liability reform. This Court should grant a writ of certiorari to address the

significant issues presented and to reverse the Tenth Circuit's erroneous decision.

A. Factual Background

Presbyterian Healthcare Services ("Presbyterian") operates Lincoln County Medical Center ("LCMC"), a hospital located in the small community of Ruidoso in southeastern New Mexico. Petitioner Valerie Miller is employed by Presbyterian as administrator of the hospital. Petitioner Vickie Williams, D.O., is a physician specializing in obstetrics and gynecology. Dr. Williams maintains a private practice in Ruidoso and is a member of the medical staff at LCMC.

Respondent Arlene Brown, M.D., is a family practice physician in Ruidoso. Respondent Family Practice Associates, P.C., is Dr. Brown's professional corporation.[1] Before 1992, Dr. Brown held clinical privileges in obstetrics and other areas at LCMC. In the area of uncomplicated obstetrics, Dr. Brown and Dr. Williams were competitors.

In July 1992, the LCMC Medical Executive Committee imposed a requirement that Dr. Brown obtain consultation when possible for any high risk obstetrical patient. This requirement was put into place, with Dr. Brown's consent, after three of her obstetrical cases were reviewed by a hospital committee including Dr. Williams and then by two specialists from outside the hospital. Both outside specialists criticized the care provided in two of the cases.

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[1] For convenience, both Respondents are referred to as "Dr. Brown" in this Petition.

One of them suggested that Dr. Brown obtain consultation in high risk cases, expressing concern that she "may not possess the current information and technical expertise to be involved" in caring for such patients. "High risk" cases for which Dr. Brown was required to consult were defined by criteria which included preterm labor.

Within six months, Dr. Brown treated two patients in circumstances that called her compliance with this consultation requirement into question. In November 1992, Dr. Brown saw a patient in her office and prescribed a drug used to control preterm labor without attempting to obtain an obstetrical consultation. In January 1993, Dr. Brown admitted a patient to LCMC in preterm labor. Dr. Brown had hospitalized the patient twice in the preceding month for occurrences of premature labor. On the first of those occasions Dr. Brown had consulted with Dr. Williams and initiated a sequence of medications recommended by Dr. Williams that controlled the labor. On the second occasion, Dr. Brown consulted with another obstetrics specialist and then initiated this sequence of medications again. On the third admission, however, Dr. Brown ordered the same sequence of medications to be initiated without first attempting to obtain a consultation. She did not seek a consultation until several hours later when the patient's labor had not been controlled through the administration of more potent medications than were previously needed.

Ms. Miller initiated the formal peer review process provided for in the LCMC Medical Staff Bylaws by requesting that the Medical Executive Committee determine whether a reduction in Dr. Brown's clinical privileges was called for in light of these two cases. Dr. Brown

requested and was granted a hearing before a panel of three physicians in accordance with the bylaws. Ms. Miller presented the hospital's position at the hearing, and Dr. Williams and Dr. Brown testified. Both sides were represented by counsel.

At the hearing, Dr. Brown testified that her office notes reflected that the November patient was experiencing contractions and "probably" showed cervical changes, and that these factors were indicative of preterm labor. Regarding the January patient, Dr. Brown expressed her belief that the consultation with Dr. Williams at the time of the patient's first hospitalization established a "protocol" for medication to be used if preterm labor should reoccur. Dr. Williams, however, testified that her initial consultation did not define a plan to be followed on subsequent occurrences of premature labor and that the situation confronting Dr. Brown at the time of the patient's third admission required a new evaluation of the patient and hence another consultation.

The hearing panel found that both the November and the January cases involved instances of preterm labor in which Dr. Brown failed to obtain a consultation when required to do so. The panel report concluded that Dr. Brown

> was competent to do uncomplicated obstetrics but panel members were concerned that she does not recognize complicated obstetrics or is reluctant to refer such cases for appropriate care and in view of the above, the panel feels that it has no choice but to recommend that Dr. Brown's privileges to practice obstetrics be removed.

The hospital board of trustees adopted this recommendation. The board subsequently modified its action to permit Dr. Brown to reapply for obstetrical privileges after obtaining additional training.

After the board's action, Ms. Miller was responsible for reporting the revocation of Dr. Brown's obstetrical privileges to the National Practitioner Data Bank as required by the HCQIA.[2] Ms. Miller and her administrative assistant completed a reporting form which included a blank for insertion of an "adverse action classification code" to be chosen from a list provided with the form. While admitting to some uncertainty, they chose a code corresponding to revocation of clinical privileges based on "incompetence/malpractice/negligence" because they felt it best fit the situation.

B. Proceedings Below

Dr. Brown filed suit in federal district court for the District of New Mexico, asserting claims for violation of the Sherman Antitrust Act, 15 U.S.C. §§ 1 & 2, and pendent state law claims. The jurisdiction of the district court was invoked under the Clayton Antitrust Act, 15 U.S.C. § 15, and under 28 U.S.C. §§ 1331 (general federal question jurisdiction), 1337 (antitrust), and 1367 (supplemental jurisdiction).

Dr. Brown claimed that (1) Ms. Miller and Dr. Williams conspired to bring about the revocation of her obstetrical privileges at LCMC, in violation of sections 1

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[2] *See infra*, Point II.

and 2 of the Sherman Act, and (2) Ms. Miller defamed her through the report submitted to the National Practitioner Data Bank.[3] Dr. Brown sought damages and injunctive relief.

Ms. Miller and Dr. Williams raised the defense of immunity under section 11111 of the HCQIA, which protects participants in medical peer review activities from antitrust and other damage claims resulting from hospital review actions that conform to three "reasonableness" criteria set forth in section 11112(a) of the statute. (App. 117-18.) Ms. Miller also invoked section 11137(c) of the HCQIA, which provides immunity for persons who report peer review actions to the Data Bank unless the report is known to be false. (App. 131.) The district court denied a motion by Ms. Miller and Dr. Williams for summary judgment on HCQIA immunity grounds (App. C), and the case proceeded to trial.

At trial, the medical records of the three cases originally reviewed by outside specialists and the two cases subsequently reviewed by the hearing panel were introduced into evidence, as were the hearing transcript and the rest of the record compiled during the review process. Many of the participants in the process testified. Both sides also presented testimony by medical experts.

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[3] These are the claims on which Dr. Brown prevailed that give rise to the questions presented for review. Dr. Brown also prevailed on a separate claim against Presbyterian for interference with her contractual relations, based on Presbyterian's dealings with a physician who sought to join Dr. Brown's practice. The contractual interference claim, and other claims on which Dr. Brown did not prevail, are not at issue.

The witnesses uniformly recognized that the kind of high risk obstetrical cases in which Dr. Brown was required to consult presented a threat of serious injury or death to the mother or fetus. Furthermore, experts for both sides concurred that the concerns expressed by the specialists who reviewed the original three cases were legitimate. Dr. Brown conceded that she had "clearly missed" a diagnosis of preeclampsia – a potentially deadly condition – in one case. According to Dr. Brown's expert, Dr. Norman Lindley, looking at those three cases "would raise questions . . . that [Dr. Brown] might not have the knowledge to treat such patients."

A defense expert testified that the hearing panel's conclusion that Dr. Brown failed to consult on a patient in preterm labor in November 1992 was reasonable. The expert also supported the panel's determination that Dr. Brown's failure to obtain a prompt consultation on the third hospitalization of the January 1993 patient was a violation of her consultation requirement. Both this expert witness and another expert physician testifying for the defense considered the revocation of Dr. Brown's obstetrical privileges to be justified by the November and January cases reviewed by the panel.

Dr. Brown herself acknowledged the reasonableness of the hearing panel's conclusions. In deposition testimony admitted at trial, she agreed that the panel's finding that she had failed to consult when necessary in the November case was "one conclusion that could have been reached, but not the only one." When Dr. Brown was asked whether a reasonable physician could decide that she should have sought a consultation promptly upon the January patient's third admission rather than waiting

until after she had ordered a repetition of the prior course of medication, she replied: "Again, that's a difference of opinion. As far as which one is reasonable, I expect they both are reasonable."

Asserting that the evidence entitled them to immunity under the HCQIA's "reasonableness" criteria, Ms. Miller and Dr. Williams moved for judgment as a matter of law on Dr. Brown's claim for damages resulting from the revocation of her privileges. Ms. Miller also moved for judgment as a matter of law under the HCQIA on Dr. Brown's defamation claim. The district court denied the motions and submitted the HCQIA immunity issues to the jury, which returned a verdict for Dr. Brown, awarding her $112,000 (trebled by the district court) on the antitrust claim against both defendants and $30,000 in compensatory damages and $75,000 in punitive damages on the defamation claim against Ms. Miller. Both defendants renewed their claims of immunity by a post-trial motion for judgment as a matter of law, which was denied. (App. B.) Ms. Miller and Dr. Williams appealed the award of antitrust and defamation damages to the Court of Appeals for the Tenth Circuit.[4]

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[4] In addition to challenging the district court's denial of their motion for judgment as a matter of law on HCQIA immunity grounds, Ms. Miller and Dr. Williams challenged the antitrust and defamation judgments on the merits. These challenges, which were rejected by the court of appeals, are not at issue in this proceeding. The parties stipulated to entry of an injunction by the district court under which Dr. Brown's privileges were restored after she obtained specified training in obstetrics. The grant of injunctive relief therefore was not appealed and is not presently at issue.

The appeal thus turned on the showing necessary to establish immunity from damages under the HCQIA as a matter of law. With respect to Dr. Brown's claim for damages resulting from the revocation of her obstetrical privileges, Ms. Miller and Dr. Williams argued that the HCQIA imposed an objective standard of reasonableness on peer review actions that was satisfied by the evidence. With respect to the defamation claim, Ms. Miller argued that she qualified for immunity under the HCQIA because the Data Bank report was true – i.e., the hospital's conclusion that Dr. Brown had failed to obtain necessary consultations in two cases could fairly be characterized as "incompetence" or "negligence" within the ordinary meaning of those terms.

Dr. Brown argued that the evidence raised fact questions that were properly left to the jury regarding whether the hospital's action satisfied the "reasonableness" criteria of the HCQIA. She relied on the testimony of her expert Dr. Lindley.[5] He disagreed with the hearing panel's conclusions regarding the November and January cases. Dr. Lindley had reviewed 50 patient charts provided to him by Dr. Brown before trial. He testified to his opinion that Dr. Brown was a competent physician who used obstetrical consultation appropriately. Dr. Lindley

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[5] Dr. Brown also pointed to testimony from a physician who had approved her application for privileges at another hospital and did not feel that she had violated her consultation requirement or rendered inadequate care. In addition, Dr. Brown cited evidence suggesting that bias against her – for anticompetitive, religious, or other reasons – on the part of Dr. Williams or other persons associated with the hospital could have led to the revocation of her privileges.

also faulted the hospital's reliance on two cases as grounds for revoking Dr. Brown's privileges:

> Q. Do you have an opinion as to whether the panel that conducted the investigation made a reasonable effort to obtain all the facts that it should have been after?
>
> A. From what I saw I would have to say I don't think so because no mention was made of their attempt to review other charts. . . . I feel that they should have had more information. I think they should have had the same information that I had after I reviewed the remaining 50 charts.
>
> . . .
>
> Q. . . . [W]hat is your basis for your testimony that there was no reasonable basis for concluding that Dr. Brown posed a threat to patient safety?
>
> A. Well, I felt that based on the two charts that were reviewed by them that I did not come to the conclusion that she was a threat to anybody's safety on this basis, and that is why I felt that they couldn't either.
>
> Q. So we are back to the scope of the examination?
>
> A. Yes.

The Tenth Circuit upheld the damage awards, holding that the standard for judgment as a matter of law under the HCQIA had not been satisfied. The Tenth Circuit concluded that Ms. Miller and Dr. Williams were not entitled to a judgment of immunity from damages resulting from the revocation of Dr. Brown's privileges

because, "from Dr. Lindley's testimony, a reasonable jury could have found the panel's review to be unreasonably restrictive and not taken after a 'reasonable effort to obtain the facts.' " (App. 20.) Furthermore, Ms. Miller was not entitled to a judgment of immunity from defamation damages relating to the Data Bank report because "the record contains sufficient evidence from which a reasonable jury could have concluded the data bank report was false." (App. 22.)

REASONS FOR GRANTING THE PETITION

I. The Tenth Circuit's Decision Denying Immunity Under The Health Care Quality Improvement Act Because Expert Witnesses Differed As To The Reasonableness Of A Medical Peer Review Action Creates A Split Among The Circuits Regarding Application Of The "Reasonableness" Criteria Of The Act And Erroneously Rejects An Objective Reasonableness Standard That Is Essential To The Statutory Purpose.

The Health Care Quality Improvement Act of 1986 opens with a clear indication of its purpose: to address "an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review." 42 U.S.C. § 11101(5). This need arose, in the view of Congress, because "[t]he increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems" that "can be remedied through effective professional peer review." *Id.* § 11101(1), (3). However, "[t]he threat of private money damage liability under Federal

laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review." *Id.* § 11101(4). *See Patrick v. Burget*, 486 U.S. 94, 105 n.8 (1988) ("In enacting [the HCQIA], Congress clearly noted and responded to the concern that the possibility of antitrust liability will discourage effective peer review."); *see also Summit Health, Ltd. v. Pinhas*, 500 U.S. 322, 342 (1991) (Scalia, J., dissenting) ("Disputes over the denial of hospital practice privileges are common. . . . Federal courts are an attractive forum, and the treble damages of the Clayton Act an attractive remedy.").

Consequently, the HCQIA places a limitation on the recovery of damages arising out of hospital peer review or other "professional review" actions. 42 U.S.C. § 11111(a); *see also id.* § 11151(9) (defining "professional review action"). Peer review bodies and participants in the review process "shall not be liable in damages under any law of the United States or of any State" as a result of a professional review action, provided the action meets the standards set forth in section 11112(a). 42 U.S.C. § 11111(a)(1).[6]

Section 11112(a) provides that, in order to give rise to protection from damages under the HCQIA,

> a professional review action must be taken –
>
> (1) in the reasonable belief that the action was in the furtherance of quality health care,

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[6] Immunity from damages does not apply to civil rights claims or to actions by the United States or the attorney general of any State. *Id.*

> (2) after a reasonable effort to obtain the facts of the matter, [and]
>
> . . .
>
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts. . . .

Id. § 11112(a).[7] These criteria are presumed to have been met "unless the presumption is rebutted by a preponderance of the evidence." *Id.*

Until the Tenth Circuit's decision, the federal circuits (and, to a very large degree, the federal district courts and state courts) had been consistent in their application of this immunity provision. The Ninth Circuit was the first to address the section 11112(a) criteria. In *Austin v. McNamara*, 979 F.2d 728 (9th Cir. 1992), the plaintiff's hospital privileges were suspended based on findings by other hospital staff physicians that he had provided substandard treatment. The plaintiff asserted federal antitrust and state tort claims against these physicians. The court of appeals upheld a grant of summary judgment on HCQIA immunity grounds, concluding that

> [t]he legislative history of § 11112(a) indicates that its reasonableness requirements were intended to create an objective standard. . . . Thus, our inquiry focuses on whether [the plaintiff] has provided sufficient evidence to permit a jury to find that he has overcome, by a preponderance of the evidence, the presumption that

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[7] Section 11112(a)(3) requires that "adequate notice and hearing procedures" be afforded to the physician under review. There is no dispute that this requirement was met here.

> physicians in the defendants' position would reasonably have believed that their action was warranted by the facts.

Id. at 734.[8] The objective standard of what a reasonable physician reviewer "would reasonably have believed" in the circumstances was subsequently taken up by the Third, Fourth, and Eleventh Circuits. *See Mathews v. Lancaster Gen. Hosp.*, 87 F.3d 624, 635 (3d Cir. 1996); *Imperial v. Suburban Hosp. Ass'n*, 37 F.3d 1026, 1030 (4th Cir. 1994); *Bryan v. James E. Holmes Regional Medical Ctr.*, 33 F.3d 1318, 1323 (11th Cir. 1994), *cert. denied*, 115 S. Ct. 1363 (1995); *see also Johnson v. Greater S.E. Community Hosp. Corp.*, 1996-2 Trade Cas. (CCH) ¶ 71,511, at 77,696-97 (D.D.C. 1996); *Quartemont v. St. Joseph Hosp. & Health Ctr.*, No. Civ. A. H-94-1787, 1995 U.S. Dist. LEXIS 14160, at *19 (S.D. Tex. Aug. 14, 1995); *Shilling v. Moore*, 545 N.W.2d 442, 444 (Neb. 1996); *Goodwich v. Sinai Hosp. of Baltimore, Inc.*, 680 A.2d 1067, 1073, 1078 (Md. 1996); *Ehlen v. St.*

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[8] In another often-cited passage, the Ninth Circuit dismissed the plaintiff's contention that evidence of bias or hostility on the part of the reviewers could overcome summary judgment: "[A]ssertions of hostility . . . are irrelevant to the reasonableness standards of § 11112(a). The test is an objective one, so bad faith is immaterial." 979 F.2d at 734. The Tenth Circuit did not discuss Dr. Brown's contention that the hospital review proceeding was motivated by personal animus; nor was that contention supported by Dr. Lindley, who believed that the hearing panel had acted with "as much honesty and fairness as they could." However, the district court at summary judgment stage concluded that Dr. Brown's claims of bad faith could be considered in deciding whether the HCQIA reasonableness criteria were met. (App. 80.) The Tenth Circuit allowed this ruling to pass without comment.

Cloud Hosp., No. C4-96-632, 1996 WL 589042, at *2 (Minn. Ct. App. Oct. 15, 1996).

A crucial aspect of an objective reasonableness standard is that it cannot be defeated by a mere showing that different individuals could reach different conclusions on the same facts. In *Austin v. McNamara*, a hearing committee composed of impartial doctors and a former judge ultimately concluded that the decision to suspend the plaintiff was "unreasonable." 979 F.2d at 732. The Ninth Circuit recognized, however, that this fact did not prevent the defendants from obtaining HCQIA immunity:

> The [hearing committee's] statements do call into question the ultimate reasonableness of [plaintiff's] suspension. That is a different question of "reasonableness," however, than the issue whether the defendants acted in the "reasonable belief that the [suspension] was warranted by the facts known after reasonable effort to obtain facts."

Id. at 735; *see also Mathews v. Lancaster Gen. Hosp.*, 87 F.3d at 638 (while conflicting opinions of plaintiff's expert and hospital reviewer "raise an issue of fact as to the adequacy of care provided by [plaintiff], they do not rebut the presumption that the [hospital board] made its decision in the reasonable belief that it was warranted"); *Bryan*, 33 F.3d at 1331 n.22 (evidence included expert testimony that plaintiff's actions "were proper and did not adversely affect patient care" and that "nothing in the record . . . would justify the revocation of [plaintiff's] clinical privileges"); *Fobbs v. Holy Cross Health Sys. Corp.*, 789 F. Supp. 1054, 1068-69 (E.D. Cal. 1992) (medical experts differed over need for corrective action), *aff'd in*

pertinent part, 29 F.3d 1439 (9th Cir. 1994), *cert. denied*, 115 S. Ct. 936 (1995); *Smith v. Ricks*, 798 F. Supp. 605 (N.D. Cal. 1992) (medical executive committee and review panel reached different conclusions about whether revocation of plaintiff's privileges was appropriate action), *aff'd*, 31 F.3d 1478 (9th Cir. 1994), *cert. denied*, 115 S. Ct. 1400 (1995); *Quartemont v. St. Joseph Hosp. & Health Ctr.*, 1995 U.S. Dist. LEXIS 14160, at *34 (distinguishing between disagreement with reviewers' judgment and challenge to reasonableness criteria of HCQIA). "The real issue is the sufficiency of the basis for the defendants' actions." *Austin*, 979 F.2d at 734.

The HCQIA thus provides protection for peer review activity where quality of care is a legitimate concern.[9] An objective standard is essential to the purpose of the HCQIA, because the statute is intended "not to disturb, but to reinforce, the preexisting reluctance of courts to substitute their judgment on the merits for that of health care professionals and of the governing bodies of hospitals in an area within their expertise." *Bryan*, 33 F.3d at 1337 (citation and internal quotation marks omitted).

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[9] In this respect, the approach to immunity adopted by Congress in the HCQIA bears a close relationship to this Court's determination of the standard of proof required to establish an antitrust conspiracy. *See Monsanto Co. v. Spray-Rite Serv. Corp.*, 465 U.S. 752, 763 (1984) (behavior consistent with legitimate activity, standing alone, cannot support inference of conspiracy; less restrictive rule "could deter or penalize perfectly legitimate conduct"); *see also Whren v. United States*, 517 U.S. ___, 116 S. Ct. 1769 (1996) (applying objective reasonableness standard under Fourth Amendment in manner consistent with HCQIA cases cited here).

While the Tenth Circuit acknowledged that courts have applied an objective reasonableness standard to section 11112(a) (App. 19), it nevertheless held that Dr. Lindley's testimony was sufficient to require a jury determination of the immunity defense in the present case. The Tenth Circuit seemingly did not recognize the inconsistency in its approach or the sharp conflict its decision creates with every other circuit court to address this issue:

> According to the defendants, "a difference of opinion among experts" does not raise an issue as to the objective reasonableness of the inquiry. We are not persuaded by the defendant's view. Under its theory, a peer review participant would be absolutely immune from liability for its actions so long as it produced a single expert to testify the requirements of 42 U.S.C. § 11112(a) were satisfied. This would be in direct contravention to Congress' intention to provide "qualified immunity."

(App. 20 n.9.)

The Tenth Circuit is wrong. The HCQIA is not an automatic grant of immunity to any defendant who obtains an expert witness, but it does require a plaintiff to respond with evidence properly tailored to meet the objective reasonableness standard. Specifically, it requires evidence tending to show that no reasonable reviewer could have reached the conclusions at issue. Nothing short of this sort of evidence can raise a material factual issue as to the availability of immunity under the HCQIA. *Cf. Bolt v. Halifax Hosp. Medical Ctr.*, 891 F.2d 810, 821 (11th Cir.) (legitimacy of peer review action was put in issue by expert testimony that "no reasonable medical

practitioner would have reached the same conclusions" as the hospital reviewers), *cert. denied*, 495 U.S. 924 (1990). Dr. Lindley's testimony did not address this crucial question and therefore did not put the objective reasonableness of the review action at issue. Under the Tenth Circuit's approach, HCQIA immunity will be a jury question in virtually every case, rendering immunity of little benefit to peer reviewers and frustrating the express intention of Congress that "these provisions allow defendants to file motions to resolve the issue of immunity in as expeditious a manner as possible." *Austin v. McNamara*, 979 F.2d at 734 n.5 (quoting from legislative history).

The reasonableness criteria of section 11112(a) all relate to the exercise of medical judgment by peer reviewers, and thus all three criteria should be governed by an objective reasonableness standard that insulates the reviewers from reexamination of their decisions by juries in damage suits. *See Mathews v. Lancaster Gen. Hosp.*, 87 F.3d at 635 (Congress intended objective standard to apply "with regard to § 11112(a) as a whole"). With respect to section 11112(a)(2), on which the Tenth Circuit focused, medical judgment is required to determine whether the particular cases under consideration demonstrate a sufficiently clear and substantial risk to patients as to warrant remedial action rather than forbearance or continued investigation. In a case like the present one, where the evidence establishes that reasonable physicians could find the two cases reviewed by the hearing panel to be a sufficient basis for revoking Dr. Brown's obstetrical

privileges, immunity should be conferred on the reviewers as a matter of law.[10]

Courts other than the Tenth Circuit have granted HCQIA immunity where peer reviewers determined that a small number of cases reflected a serious enough risk to justify restricting a physician's clinical privileges. *See Farr v. Healtheast, Inc.*, 1993-1 Trade Cas. (CCH) ¶ 70,294 (E.D. Pa. 1993) (review triggered by two cases, continuation of questioned practice resulted in suspension of privileges); *Fobbs v. Holy Cross Health Sys. Corp.* (monitoring requirement based on four cases; suspension based on one incident of failure to comply and physician's intent not to comply in future); *Maewal v. Adventist Health Sys./Sunbelt, Inc.*, 868 S.W.2d 886 (Tex. Ct. App. 1993) (suspension of privileges based on one case); *Babcock v. St. Francis Medical Ctr.*, 543 N.W.2d 749 (Neb. Ct. App. 1996) (anesthesiologist twice breached agreement with hospital regarding her drinking problem). "[N]othing in the

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[10] Under the Tenth Circuit's rationale, an immunity defense will require resolution of fact issues by a jury whenever medical experts disagree about the adequacy of care rendered by a physician, as well as when experts differ over the number of cases that must be examined to constitute a reasonable inquiry by a hospital. Such disagreements are likely to be common in all but the most clear-cut cases of physician incompetence. Here, for instance, although the conclusions of the hearing panel were unquestionably supported by the evidence before it, Dr. Brown subsequently obtained expert witnesses and sought to have a lay jury revisit these medical determinations in pursuit of a damage award. The Tenth Circuit would permit such an attack on an objectively reasonable peer review result, despite the strong deterrent effect it would have on legitimate review activity.

[HCQIA] . . . suggests that a reasonable effort to obtain the facts must include an evaluation of facets of a physician's practice other than those upon which a professional review action is based. . . . The Act imposes no duty to investigate a physician's entire range of conduct before taking a professional review action." *Mathews v. Lancaster Gen. Hosp.*, 883 F. Supp. 1016, 1033 (E.D. Pa. 1995), *aff'd*, 87 F.3d 624 (3d Cir. 1996); *see also Goodwich v. Sinai Hosp.*, 680 A.2d at 1079 (section 11112(a)(2) requirement satisfied "[a]s long as the [hospital] had enough information before it to justify" the challenged action).[11]

In the present case, Ms. Miller and Dr. Williams made a showing that the LCMC reviewers' decision to act on the two cases considered, like their assessment of whether the cases constituted violations of Dr. Brown's consultation requirement, met a standard of objective reasonableness: on the evidence before the hearing panel

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[11] In cases not involving the HCQIA, courts regularly uphold peer review decisions where a few instances, or even a single occurrence, of inadequate care is determined by medical reviewers to indicate a risk to patients. *See, e.g., Caine v. Hardy*, 943 F.2d 1406 (5th Cir. 1991) (one case), *cert. denied*, 503 U.S. 936 (1992); *Darlak v. Bobear*, 814 F.2d 1055 (5th Cir. 1987) (one case); *Stitzell v. York Memorial Osteopathic Hosp.*, 754 F. Supp. 1061 (M.D. Pa. 1991) (single case triggered external review; two additional cases resulted in summary suspension, subsequently modified); *Citta v. Delaware Valley Hosp.*, 313 F. Supp. 301 (E.D. Pa. 1970) (one case); *Storrs v. Lutheran Hosps. & Homes Soc'y of Am., Inc.*, 661 P.2d 632 (Alaska 1983) (one case); *Scappatura v. Baptist Hosp.*, 584 P.2d 1195 (Ariz. Ct. App. 1978) (one case); *Moore v. Board of Trustees*, 495 P.2d 605 (Nev.) (one clinical case plus cancellation of a surgery), *cert. denied*, 409 U.S. 879 (1972); *Clough v. Adventist Health Sys., Inc.*, 780 P.2d 627 (N.M. 1989) (restrictions based on single case).

a reasonable physician could have reached the conclusions that were reached by the panel members and acted upon by the hospital board. Dr. Lindley's testimony that he considered two cases to be an insufficient basis for the hospital's action does not call this showing into question. A reasonable physician could have concluded that Dr. Brown could not be relied upon to consult in high risk cases and that she posed a risk to patients. Ms. Miller and Dr. Williams were entitled to HCQIA immunity as a matter of law.

In *Patrick v. Burget,* this Court noted that the then relatively new HCQIA "essentially immunizes peer-review action from liability" if the reasonableness standards of section 11112(a) are met. 486 U.S. at 105 n.8. The decision of the court of appeals in the present case makes the promise of the statute illusory in the Tenth Circuit and jeopardizes its efficacy in the remaining Circuits that have not yet determined the standard for granting immunity under the HCQIA. It is imperative that the immunity standards established by Congress to address a "nationwide" public health problem, 42 U.S.C. § 11101(1) & (3), be uniformly and correctly applied. The effective peer review that Congress sought to promote through the HCQIA will be deterred by an inadequate standard for immunity. A writ of certiorari should be granted to review the Tenth Circuit's decision in this case.

II. The Tenth Circuit's Denial Of Immunity For Reporting A Medical Peer Review Action To The National Practitioner Data Bank In Terms That, Under Their Ordinary Meaning, Are Accurate Also Reflects An Improper Standard For Immunity That Frustrates The Purpose Of The Health Care Quality Improvement Act.

The HCQIA creates a National Practitioner Data Bank to which information on hospital peer review actions, medical licensure actions, and medical malpractice payments must be reported; hospitals are required to query the Data Bank for information on applicants for medical staff privileges and periodically regarding members of the medical staff. *See* 42 U.S.C. §§ 11131-11136. This aspect of the statute is intended by Congress to limit the ability of incompetent physicians to hide their records by moving from one institution to another. *See id.* § 11101(2).

Just as the HCQIA provides immunity designed to promote effective peer review, the statute also includes an immunity provision aimed at encouraging compliance with its reporting requirements. Section 11137(c) of the HCQIA confers immunity on any person who makes a report to the Data Bank "without knowledge of the falsity of the information contained in the report." 42 U.S.C. § 11137(c). Hence, immunity for reporting exists as a matter of law unless there is evidence sufficient for a jury to find both that the report was false and that the reporting party knew it was false.

The Tenth Circuit held that the jury could find that the Data Bank report submitted by LCMC was false because there was no express finding by the reviewers that Dr. Brown was negligent or incompetent or had

committed malpractice. As the Tenth Circuit characterized it, the hearing panel only found that Dr. Brown had breached an agreement to obtain appropriate consultation. (App. 22.)

The hearing panel recommended revocation of Dr. Brown's obstetrical privileges, however, because it found that she either could not or would not recognize complicated obstetrical cases. There was no dispute among the trial witnesses, even including Dr. Brown, that a family practitioner should consult a specialist in obstetrics when dealing with high risk cases for the protection of the patient. The panel's finding that Dr. Brown was unable or unwilling to abide by her consultation requirement was no less than a finding that Dr. Brown was "incompetent" or "negligent" – i.e., that she failed to recognize cases that were high risk or failed to do a required thing – within the ordinary meaning of those terms. *See* Webster's New World Dictionary 737, 982 (college ed. 1968).

Ms. Miller was entitled to immunity under section 11137(c) because the Data Bank report was accurate within the ordinary meaning of the language used. Even under the usual standards of defamation law, it is difficult to understand how a basis for liability could be found on this record. *See, e.g., Hein v. Lacy*, 616 P.2d 277, 284-85 (Kan. 1980) (no claim for defamation where challenged statement was true under common interpretation of language); *Altman v. Amoco Oil Co.*, 406 N.E.2d 142, 144 (Ill. App. Ct. 1980) (adverse credit rating code would not support defamation claim where code could be interpreted to fit facts); *cf. Robertson v. Rodriguez*, 42 Cal. Rptr. 2d 464 (Ct. App. 1995) (where report that plaintiff had paid fine was true under broader definition of "fine,"

defendant could not be found to have made report with knowledge that it was false); *Shilling v. Moore*, 545 N.W.2d 442, 446 (Neb. 1996) (libel claim against hospital department chairman who prepared report concerning plaintiff's application for reappointment to medical staff was properly dismissed where report accurately "reflect[ed] concerns raised by [plaintiff's] peer reviewers") (citing HCQIA); *see also Masson v. New Yorker Magazine, Inc.*, 501 U.S. 496, 516, 519 (1991) (libel law looks to "substantial truth" of challenged statements and protects "rational interpretations" of ambiguous events).

Moreover, the HCQIA authorizes, and the Department of Health and Human Services has adopted, regulations defining a procedure for resolving disputes over the accuracy of a Data Bank report. *See* 42 U.S.C. § 11136(2) (App. 129); 45 C.F.R. § 60.14 (1996). Where a physician disputes a report and the reporting entity does not change it, the physician can request that the Department review written information from both parties and make a final decision regarding whether the report is accurate. Dr. Brown did not follow this procedure. Because the HCQIA is intended to promote reporting and provides a mechanism to remedy any harm stemming from reports that might be subject to several interpretations, it is consistent with Congressional design and appropriate as a matter of federal law to interpret section 11137(c) as protecting from defamation claims those who make reports that are true on their face according to the usual meaning of the terms used in the report. The Tenth Circuit's conclusion that issues of fact remain frustrates the purpose of the HCQIA by allowing a jury to penalize a

reporting party for submitting a Data Bank report that is facially correct.

The Tenth Circuit's treatment of immunity for Data Bank reports under section 11137(c) is of a piece with its application of the section 11112(a) criteria to claims of immunity for peer review actions. In both instances the court of appeals has ignored Congressional intent and adopted a standard that defeats the purpose Congress sought to achieve in enacting the HCQIA. The record in this case sharply frames two important issues regarding HCQIA immunity. In addition to granting a writ of certiorari to review the Tenth Circuit's application of the section 11112(a) "reasonableness" criteria, this Court should extend the writ to embrace the Tenth Circuit's interpretation of the standard for Data Bank reporting immunity under section 11137(c). The Court should reverse the Tenth Circuit's erroneous decision.

CONCLUSION

The petition for writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX A

PUBLISH

UNITED STATES COURT OF APPEALS

TENTH CIRCUIT

ARLENE M. BROWN, M.D.; FAMILY PRACTICE ASSOCIATES, P.C.,

Plaintiffs-Appellees,

v.

PRESBYTERIAN HEALTHCARE SERVICES; VALERIE MILLER; VICKIE WILLIAMS, D.O.,

Defendants-Appellants,

and

SIERRA BLANCA MEDICAL ASSOCIATES, P.A.; GARY JACKSON, D.O.,

Defendants.

No. 95-2293

(Filed Nov. 29, 1996)

ARLENE M. BROWN, M.D., FAMILY PRACTICE ASSOCIATES, P.C.,

Plaintiffs-Appellants,

v.

PRESBYTERIAN HEALTHCARE SERVICES, VALERIE MILLER, SIERRA BLANCA MEDICAL ASSOCIATES, P.A., VICKIE WILLIAMS, D.O., GARY JACKSON, D.O.,

Defendants-Appellees.

No. 96-2013

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF NEW MEXICO (D.C. No. CIV-93-719-JP)

Thomas C. Bird (David W. Peterson of Keleher & McLeod, P.A.; and Phil Krehbiel of Krehbiel, Bannerman, Horn & Hisey, P.A., Albuquerque, NM, with him on the briefs) of Keleher & McLeod, P.A., Albuquerque, NM, for Plaintiffs-Appellees.

Bruce Hall (Edward Ricco and Theresa W. Parrish with him on the briefs) of Rodey, Dickason, Sloan, Akin & Robb, P.A., Albuquerque, NM, for Defendants-Appellants.

Before BRORBY, RONEY,* and LOGAN, Circuit Judges.

BRORBY, Circuit Judge.

Dr. Arlene Brown, a family physician, and her professional association, Family Practice Associates, P.C. (hereinafter collectively referred to as "Dr. Brown"), brought

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* The Honorable Paul H. Roney, Senior United States Circuit Judge for the Eleventh Circuit, sitting by designation.

suit against Presbyterian Healthcare Services, Valerie Miller, Vickie Williams, D.O., Sierra Blanca Medical Associates, P.A., and Gary Jackson, D.O., seeking injunctive relief and damages for violation of Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1 and 2 (1994), unreasonable restraint of trade and unfair trade practices in violation of Section 57 of the New Mexico Annotated Statutes, bad faith breach of contract, intentional interference with contract, defamation, and *prima facie* tort. Dr. Brown's causes of action arose from the revocation of her obstetrical hospital staff privileges by Lincoln County Medical Center,[1] and from the hospital's subsequent report of this revocation to the National Practitioner Data Bank under the category of "Incompetence/Malpractice/Negligence." According to Dr. Brown, the defendants' "anticompetitive motives" were at the heart of these actions.

After a three week jury trial, the jury rendered a verdict in favor of Dr. Brown on the defamation claim, tortious interference with contract claim, and certain of her antitrust claims. Thereafter, the district court set aside the jury's awards of damages on the tortious interference with contract claim, and the jury's award of punitive damages against Dr. Williams on the antitrust claims. Dr. Brown and Defendants Presbyterian Healthcare Services, Ms. Miller and Dr. Williams appeal from the district court's order and amended judgment.

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[1] Defendant Presbyterian Healthcare Services, a nonprofit New Mexico corporation, manages and operates Lincoln County Medical Center under an agreement with Lincoln County, New Mexico.

I. Factual Background

Dr. Arlene Brown, a Board-certified family physician, began practicing family medicine in Ruidoso, New Mexico, in 1983. Dr. Brown joined the medical staff of Lincoln County Medical Center, and in 1992 she held clinical privileges at the hospital in obstetrics and other areas. Dr. Vickie Williams, a physician specializing in obstetrics and gynecology in Ruidoso, is an economic competitor of Dr. Brown.

In early 1992, Dr. Williams participated in an informal peer review of three patients treated by Dr. Brown. Dr. Williams expressed concerns about the quality of care reflected in the patients' charts and prepared typewritten comments on the charts. Valerie Miller, Lincoln County Medical Center's Administrator, then referred the charts to specialists outside the hospital for review. The outside reviewing physicians' comments were submitted to Lincoln County Medical Center's Executive Committee. At a meeting of the Executive Committee on July 13, 1992, Dr. Brown agreed to a requirement to consult with an obstetrics specialist in treating high-risk obstetrical patients.

In February 1993, Valerie Miller instituted formal peer review proceedings against Dr. Brown by sending a complaint to the Medical Staff Executive Committee, charging Dr. Brown with failure to abide by the consultation agreement. The Executive Committee instituted formal peer review proceedings against Dr. Brown by appointing a panel of three physicians to conduct a hearing on the complaint. At the hearing in April 1993, the panel reviewed the charts of two patients treated by Dr. Brown and heard testimony from Dr. Williams and Dr.

Brown. The next day, the hearing panel issued its report, concluding Dr. Brown breached her agreement to obtain appropriate consultation and recommending removal of Dr. Brown's obstetrical privileges. Thereafter, the Medical Executive Committee approved the panel's recommendation and Lincoln County Medical Center's Board of Trustees adopted the recommendation.[2]

Following the Board of Trustees' disciplinary action, Lincoln County Medical Center submitted a report to the National Practitioner Data Bank concerning the revocation of Dr. Brown's obstetrical privileges.[3] Glenda Perry, the hospital's medical staff coordinator, prepared the report in collaboration with Ms. Miller. One blank on the report called for insertion of an "Adverse Action Classification Code." Ms. Perry and Ms. Miller settled on the code entitled "Incompetence/ Malpractice/ Negligence."

When Dr. Brown received a copy of the hospital's data bank report, she submitted a report of her own to

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[2] Dr. Brown subsequently appealed the Board of Trustees' decision. However, on May 20, 1993, the Board's Appeal Panel affirmed the Board of Trustees' decision, with one minor modification. The modification allowed Dr. Brown to reapply for privileges after fulfilling certain training requirements.

[3] The National Practitioner Data Bank is an organization created under the Health Care Quality Improvement Act to collect information on physicians, including reports of adverse peer review actions. See 45 C.F.R. Part 60 (1995). "Each health care entity must report to the Board of Medical Examiners . . . [a]ny professional review action that adversely affects the clinical privileges of a physician." 45 C.F.R. § 60.9(a). The Board of Medical Examiners must in turn report this information to the National Practitioner Data Bank. 45 C.F.R. § 60.9(b).

the National Practitioner Data Bank stating Lincoln County Medical Center never found her negligent, incompetent or guilty of malpractice. The National Practitioner Data Bank then notified Lincoln County Medical Center of Dr. Brown's objection to the report, and provided the hospital with an opportunity to revise its report. However, the hospital elected not to amend the data bank report.

Although unrelated to the revocation of Dr. Brown's obstetrical privileges, in 1992 a family practice physician named Dr. Mark Reib contacted a Presbyterian Healthcare Services recruiter to discuss family medicine practice opportunities in Ruidoso, New Mexico. When Dr. Reib expressed an interest in joining Dr. Brown's practice, the recruiter informed Dr. Reib the hospital would only offer him a financial recruitment package if he were to go to work for Lincoln County Medical Center or in direct competition with Dr. Brown. Dr. Reib chose not to join Dr. Brown's medical practice.

II. Trial and Subsequent Procedural History

In March 1995, the trial of this action commenced before a jury. Almost three weeks later, the jury returned a special verdict in Dr. Brown's favor on her defamation claim, intentional interference with contract claim, and on certain of her antitrust claims.[4] The district court entered

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[4] Specifically, the jury entered the following awards of damages: (1) $112,000.00 against Ms. Miller and Dr. Williams on the antitrust claims; (2) $30,000.00 against Ms. Miller on the defamation claim; (3) $7,500.00 in compensatory damages and

judgment in accordance with the jury's findings, trebling, as required by law,[5] the antitrust damages against Ms. Miller and Dr. Williams. Thereafter, pursuant to Fed.R.Civ.P. 50(b) and 59(c), the defendants filed a motion for judgment as a matter of law or to alter or amend the judgment or for a new trial. In a comprehensive and detailed "Memorandum Opinion and Order," the district court set aside the jury's award of compensatory and punitive damages against Presbyterian Healthcare Services on the intentional interference with contract claim, and the jury's award of punitive damages against Dr. Williams on the antitrust claim.[6] The district court rejected all of the defendants' remaining arguments and entered an amended judgment in conformity with its opinion.

Dr. Brown appeals the district court's amended judgment, raising two issues: (1) whether the district court erred in vacating the compensatory and punitive damages awards for tortious interference with contract and (2) whether the district court erred in vacating the punitive damages award against Dr. Williams. The appeal of

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$75,000.00 in punitive damages against Presbyterian Healthcare Services on the intentional interference with contract claim; (4) $75,000.00 in punitive damages against Ms. Miller on the antitrust and defamation claims; and (5) $75,000.00 in punitive damages against Dr. Williams on the antitrust claims. The jury found in favor of defendants Dr. Jackson and Sierra Blanca Medical Associates with respect to all claims against them.

[5] See 15 U.S.C. § 15(a) (1994).

[6] The court set aside the former pursuant to Fed.R.Civ.P. 50(b), and the latter pursuant to Fed.R.Civ.P. 59(e).

Presbyterian Healthcare Services, Ms. Miller and Dr. Williams raises four issues: (1) whether the district court erred in determining the defendants were not immune as a matter of law from damages resulting from the revocation of Dr. Brown's obstetrical privileges; (2) whether the district court erred in determining the defendants were not immune as a matter of law from damages resulting from the data bank report; (3) whether the district court erred in denying the defendants' motion for judgment as a matter of law on the merits of Dr. Brown's antitrust claims; and (4) whether the district court erred in denying the defendants' motion for judgment as a matter of law on the merits of Dr. Brown's defamation claim. After thoroughly reviewing the parties' briefs, the district court's Memorandum Opinion and Order, and all relevant statutes and case law, we conclude the district court erred in setting aside the jury's awards of damages on Dr. Brown's intentional interference with contract claim. However, with respect to the remaining issues raised by the parties on appeal, we find the district court's rulings were proper and in accordance with law.

III. Dr. Brown's Appeal

Dr. Brown first contends the district court erred in vacating as a matter of law the jury's award of compensatory and punitive damages against Presbyterian Healthcare Services on the tortious interference with contract claim. The Court reviews the district court's order granting judgment as a matter of law de novo, applying the same standard as the district court. *Thompson v. State Farm Fire & Casualty Co.*, 34 F.3d 932, 941 (10th Cir. 1994). The legal standard for granting judgment as a matter of

law is identical to the standard for granting summary judgment under Fed.R.Civ.P. 56. *Pendleton v. Conoco, Inc.*, 23 F.3d 281, 286 (10th Cir. 1994). When applying this standard, a court is to examine the factual record and reasonable inferences therefrom in the light most favorable to the party opposing the motion for summary judgment or judgment as a matter of law. *Wolf v. Prudential Ins. Co.*, 50 F.3d 793, 796 (10th Cir. 1995) (citing *Applied Genetics Int'l, Inc. v. First Affiliated Sec., Inc.*, 912 F.2d 1238, 1241 (10th Cir. 1990)). Judgment as a matter of law should be affirmed only if the evidence is insufficient to permit a jury to properly return a verdict in the opposing party's favor. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 257 (1985).

In the present case, the jury found Presbyterian Healthcare Services liable for tortious interference with contract and awarded Dr. Brown $7,500.00 in compensatory damages and $75,000.00 in punitive damages on this claim. In its Memorandum Opinion and Order, however, the district court vacated the award of compensatory damages, concluding Dr. Brown had failed to present adequate proof of actual damages on this claim. Since the punitive damages award for tortious interference "was connected only to the jury's finding that [Presbyterian Healthcare Services] intentionally interfered with plaintiffs' contractual relations," the district court also set aside the $75,000.00 punitive damages award.

Dr. Brown claims the district court erred in vacating the awards of damages for tortious interference with contract because the record contains sufficient evidence to support the jury's awards. Presbyterian Healthcare Services, on the other hand, contends Dr. Brown did not

establish damages for tortious interference with "reasonable certainty" and therefore, the district court properly set aside the jury's awards of damages on this claim. As noted by the district court, damages that are based on conjecture, speculation, or guesswork are not recoverable. *Smith v. Babcock Poultry Farms, Inc.*, 469 F.2d 456, 459 (10th Cir. 1972) (citing *United States v. Griffith, Gornall & Carman, Inc.*, 210 F.2d 11 (10th Cir. 1954)). However, the fact damages are difficult to ascertain will not necessarily bar recovery. *Id.* Under New Mexico law, which is applicable in the present case, "[t]he lack of certainty that will prevent a recovery is uncertainty as to the fact of damages, not as to the amount." *Camino Real Mobile Home Park Partnership v. Wolfe*, 891 P.2d 1190, 1201 (N.M. 1995). Damages need not be computed with "mathematical certainty" and recovery will not be denied where the evidence "afford[s] a reasonable basis for estimating [plaintiff's] loss." *Archuleta v. Jacquez*, 103 N.M. 254, 704 P.2d 1130, 1134 (N.M. Ct. App.1985). In reviewing a jury's award of damages, the court should sustain the award unless it is clearly erroneous or there is no evidence to support the award. *Hudson v. Smith*, 618 F.2d 642, 646 (10th Cir. 1980).

Here, Dr. Brown's alleged damages for intentional interference with contract stem from Presbyterian Healthcare Services' interference with Dr. Brown's attempts to hire Dr. Mark Reib. In an effort to prove the hospital's interference with Dr. Reib caused her damages, Dr. Brown presented testimony at trial from Dr. Michael McDonald, an economic expert. Dr. McDonald testified

regarding the additional patient receipts Dr. Steven Frey,[7] a family practitioner who joined Dr. Brown's practice in May 1992, brought in to Dr. Brown's practice in 1992 and 1993. According to Dr. McDonald, Dr. Frey's patient receipts averaged around $6,000.00 per month in 1992, and almost $15,000.00 per month in 1993. Dr. McDonald also testified concerning the additional costs Dr. Brown would have incurred in obtaining additional patient revenues. Based on Dr. Brown's 1993 financial statements, Dr. McDonald determined Dr. Brown's costs would increase by 34.1 cents for every dollar of additional receipts. Hence, Dr. McDonald concluded "65.9 percent of any increment in patient receipts will go to the bottom line, the net income of [Dr. Brown's practice]."

Dr. George Rhodes, Jr., an economist for the defense, also testified concerning the additional revenue Dr. Frey brought in to Dr. Brown's practice in 1992 and 1993. Dr. Rhodes testified the hiring of Dr. Frey increased the revenue to Dr. Brown's practice by $15,000.00 to $20,000.00 per month in 1993. Additionally, Dr. Rhodes firmly concluded the addition of another physician to Dr. Brown's practice would result in an increase in the practice's revenue.

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[7] The court notes the credentials and background of Dr. Frey and Dr. Reib are strikingly similar. Dr. Frey completed a family practice residency in 1983, while Dr. Reib completed a family practice residency in 1984. Following completion of their respective residency programs, Dr. Frey and Dr. Reib each spent three to four years in the Navy. Apparently, the two doctors were stationed together on Guam and became friends. Dr. Frey and Dr. Reib each entered a private family medicine practice after their respective stints in the Navy.

From the above testimony, it is clear Presbyterian Healthcare Services' interference with the hiring of Dr. Reib caused financial harm to Dr. Brown's practice. Although the testimony of Dr. McDonald and Dr. Rhodes does not provide a precise model for determining the extent of Dr. Brown's damages, it does provide a reasonable basis for estimating the plaintiff's loss. From the testimony regarding the amount of additional revenue Dr. Frey brought into Dr. Brown's practice, the jury could have reasonably determined the hiring of Dr. Reib would have resulted in a similar increase in revenue. Such a determination finds support in New Mexico law (*see, e.g., Ranchers Exploration & Dev. Corp. v. Miles*, 696 P.2d 475, 477 (N.M. 1985) (historic profits of established business may be considered in determining lost profits) (citing *J.R. Watkins Co. v. Eaker*, 56 N.M. 385, 244 P.2d 540, 544 (N.M. 1952)), and is particularly sound in light of the similar training and professional backgrounds of Dr. Frey and Dr. Reib, and the temporal proximity of the period in which Dr. Frey began his employment with Dr. Brown to the period in which Presbyterian Healthcare Services interfered with the hiring of Dr. Reib. Finally, from Dr. McDonald's testimony concerning the amount of additional costs Dr. Brown would have incurred from increased patient revenues, the jury could have reached a rational conclusion as to the amount of lost profits Dr. Brown's practice incurred due to Presbyterian Healthcare Services' tortious interference with contract.

As explained in Restatement (Second) of Torts, once an injured person establishes his business or transaction would have been profitable,

> it is not fatal to the recovery of substantial damages that he is unable to prove with definiteness the amount of the profits he would have made or the amount of harm that the defendant has caused. It is only essential that he present such evidence as might reasonably be expected to be available under the circumstances.

Restatement (Second) of Torts § 912(d), at 483 (1979). Given the circumstances of this case, we believe the evidence concerning the increase in revenues resulting from the recruitment of Dr. Frey was a reasonable method of establishing damages. This is especially so in light of the fact that the certainty of damages "was 'made hypothetical by the very wrong' of the defendant." *See* Restatement (Second) of Torts § 774A comt. c (1979). We find the jury's award of compensatory damages to be reasonably based upon sufficient evidence in the record, and we therefore reverse the district court's order vacating this award.

Having reversed the district court's order vacating the jury's award of compensatory damages for tortious interference with contract, we must next determine whether its order setting aside the jury's award of punitive damages on this claim should stand. The district court set aside the punitive damages award solely because it was dependent on the jury's award of compensatory damages on the tortious interference claim. Since we have reinstated the compensatory damages award, the punitive damages award likewise must be reinstated. We therefore reverse the district court's order vacating the jury's award of punitive damages on the tortious interference with contract claim.

Dr. Brown also contends the district court erred in setting aside the jury's award of punitive damages against Dr. Williams on the antitrust claim. The district court did so pursuant to Fed.R.Civ.P. 59(e), which ruling we review for abuse of discretion. *Webber v. Mefford*, 43 F.3d 1340, 1345 (10th Cir. 1994). Under the abuse of discretion standard,

> a trial court's decision will not be disturbed unless the appellate court has a definite and firm conviction that the lower court made a clear error of judgment or exceeded the bounds of permissible choice in the circumstances. When we apply the "abuse of discretion" standard, we defer to the trial court's judgment because of its firsthand ability to view the witness or evidence and assess credibility and probative value.

Moothart v. Bell, 21 F.3d 1499, 1504 (10th Cir. 1994) (quoting *McEwen v. City of Norman*, 926 F.2d 1539, 1553-54 (10th Cir. 1991)). In this circuit, abuse of discretion is defined as " 'an arbitrary, capricious, whimsical, or manifestly unreasonable judgment.' " *FDIC v. Oldenburg*, 34 F.3d 1529, 1555 (10th Cir. 1994) (quoting *United States v. Hernandez-Herrera*, 952 F.2d 342, 343 (10th Cir. 1991)).

In the present case, the jury found Dr. Williams liable on the antitrust conspiracy claims and awarded punitive damages against her in the amount of $75,000.00. Thereafter, in accordance with 15 U.S.C. § 15(a) (1994),[8] the

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[8] 15 U.S.C. § 15(a) provides in pertinent part, "any person who shall be injured . . . by reason of anything forbidden in the antitrust laws . . . shall recover threefold the damages by him sustained."

district court entered an award of treble damages against Dr. Williams on the antitrust claims. However, the district court vacated the jury's award of punitive damages against Dr. Williams, noting such an award would be duplicative because the treble damages provision already embodies punitive damages.

Dr. Brown now contends the district court erroneously set aside the punitive damages award because "[t]he Defendants proposed a verdict form calling for punitive damages for antitrust violations." According to Dr. Brown, the defendants "invited" the jury to erroneously award punitive damages against Dr. Williams, and consequently, the defendants are now precluded from seeking judicial review of this "invited error." As an initial matter, the court notes it is clearly improper to allow a plaintiff to recover punitive damages along with trebled damages on an antitrust claim. "Punitive damages beyond the statutory trebled damages cannot be awarded for an antitrust violation. The enhancement of damages in an antitrust case is the damages trebled." *McDonald v. Johnson & Johnson*, 722 F.2d 1370, 1381 (8th Cir. 1983) (citing *Clark Oil Co. v. Phillips Petroleum Co.*, 148 F.2d 580, 582 (8th Cir.) (treble damage provision encompasses both punitive and compensatory damages), *cert. denied*, 326 U.S. 734 (1945)). *See also Spence v. Southeastern Alaska Pilots' Ass'n*, 789 F.Supp. 1014, 1029 (D.Alaska 1992) ("[p]unitive damages are not available on federal antitrust claims").

Notwithstanding the patent impropriety of allowing a plaintiff to recover punitive damages on an antitrust claim, Dr. Brown argues Dr. Williams' failure to object to the jury instructions and verdict sheet that permitted the

recovery of such damages serves to preclude subsequent judicial review of the jury's award of punitive damages. As Dr. Brown points out, an appellant may not generally complain on appeal of errors he has himself induced or invited. *See, e.g., Meredith v. Beech Aircraft Corp.*, 18 F.3d 890 (10th Cir. 1994) (citing *Gundy v. United States*, 728 F.2d 484, 488 (10th Cir. 1984)). However, where the jury has returned a special verdict, the trial judge is obligated to apply appropriate legal principles to the facts found by the jury. *Thedorf v. Lipsey*, 237 F.2d 190, 193 (7th Cir. 1956). "[I]t is for the court to decide upon the jury's answers . . . what the resulting legal obligation is." *Id.* Moreover, in determining whether to grant or deny a Rule 59(e) motion to alter or amend the judgment, the district court is vested with considerable discretion. *Edward H. Bohlin Co. v. Banning Co.*, 6 F.3d 350, 355 (5th Cir. 1993) (citing *Lavespere v. Niagara Machine & Tool Works, Inc.*, 910 F.2d 167, 174 (5th Cir. 1990)). The district court may grant a motion to alter or amend the judgment where it is necessary to correct manifest errors of law. Charles Alan Wright et al., *Federal Practice and Procedure: Civil 2d* § 2810.1, at 124-25 (1995).

In the case at bar, the jury instructions and special verdict form were exhaustive and labyrinthine. The jury's responsibilities included determining the liability of six defendants for as many as seven distinct claims. The special verdict form alone was twelve pages and contained more than thirty individual questions. Given the numerous parties, claims and overall complexity of the case, we do not believe the trial judge abused his discretion in vacating the jury's award of punitive damages against Dr. Williams. As stated in the district court's

Memorandum Opinion and Order, "it would have been impractical and confusing to the jury to have drafted the special verdict to include all of the combinations of circumstances under which punitive damages could or could not have been awarded against various defendants." The district court's decision to vacate the award of punitive damages served to correct a manifest error of law and did not prejudice Dr. Brown. Under these circumstances, we are *not* left with "a definite and firm conviction that the lower court made a clear error of judgment or exceeded the bounds of permissible choice in the circumstances." Hence, we affirm the district court's order vacating the award of punitive damages against Dr. Williams.

IV. Appeal of Presbyterian Healthcare Services, Dr. Williams and Ms. Miller

Presbyterian Healthcare Services, Dr. Williams and Ms. Miller contend the district court erred in: (1) failing to find the defendants immune, as a matter of law, from antitrust and defamation damages under the Health Care Quality Improvement Act and (2) failing to grant judgment as a matter of law in the defendants' favor on the merits of Dr. Brown's antitrust and defamation claims. As stated, we review the denial of a motion for judgment as a matter of law de novo, applying the same legal standard used by the district court. *Thompson*, 34 F.3d at 941. Judgment as a matter of law should only be granted if the evidence, when viewed in the light most favorable to the party opposing the motion, could not support a verdict in that party's favor. *Anderson*, 477 U.S. at 257.

First, the defendants argue the trial court erred in failing to find them immune, as a matter of law, from damages resulting from the revocation of Dr. Brown's obstetrical privileges, under the Health Care Quality Improvement Act. In 1986, Congress adopted the Health Care Quality Improvement Act in response to "[t]he increasing occurrence of medical malpractice and the need to improve the quality of medical care." *See* 42 U.S.C. § 11101(1), (2) (1994). Recognizing "[t]he threat of private money damage liability . . . unreasonably discourages physicians from participating in effective professional peer review," *see* 42 U.S.C. § 11101(4), Congress deemed it essential for the legislation to provide qualified immunity from damages actions for hospitals, doctors and others who participate in professional peer review proceedings. *Imperial v. Suburban Hosp. Ass'n, Inc.*, 37 F.3d 1026, 1028 (4th Cir. 1994). Thus, under the Health Care Quality Improvement Act, a peer review participant is immune from private damage claims stemming from the peer review action provided the review action is taken:

> (1) in the reasonable belief that the action was in the furtherance of quality health care,
>
> (2) after a reasonable effort to obtain the facts of the matter,
>
> (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
>
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

42 U.S.C. §§ 11111(a)(1), 11112(a) (1994). A peer review action is presumed to have met the preceding standards necessary for immunity. 42 U.S.C. § 11112. However, if a plaintiff challenging a peer review action proves, by a preponderance of the evidence, any one of the four requirements was not satisfied, the peer review body is no longer afforded immunity from damages under the Health Care Quality Improvement Act. 42 U.S.C. § 11112(a); *see, e.g., Islami v. Covenant Medical Center, Inc.*, 822 F.Supp. 1361, 1377-78 (N.D. Iowa 1992) (review participants not entitled to immunity as matter of law because plaintiff presented sufficient evidence for a jury to conclude review participants did not provide plaintiff with fair and adequate process). Courts apply an objective standard in determining whether a peer review action was reasonable under 42 U.S.C. § 11112(a). *See, e.g., Mathews v. Lancaster Gen'l Hosp.*, 87 F.3d 624, 635 (3d Cir. 1996); *Austin v. McNamara*, 979 F.2d 728, 734 (9th Cir. 1992).

In the present case, the formal peer review hearing was held to determine whether Dr. Brown had agreed to seek consultation for high-risk obstetrical patients and if so, whether Dr. Brown had breached this agreement. During the hearing, Ms. Miller outlined the hospital's position, and the Panel reviewed the charts of two patients Dr. Brown treated. Both Dr. Williams and Dr. Brown testified at the hearing. Following approximately two hours of deliberations, the review panel concluded Dr. Brown had breached her agreement to obtain appropriate consultation and recommended removal of Dr. Brown's privileges to practice obstetrics at Lincoln County Medical Center.

At trial, Dr. Brown presented sufficient evidence for a reasonable jury to find, by a preponderance of the evidence, the peer review action was not taken after a "reasonable effort to obtain the facts of the matter." Dr. Norman Lindley, a physician specializing in obstetrics and gynecology, testified on behalf of Dr. Brown. Dr. Lindley reviewed the charts for every obstetrics patient Dr. Brown treated for the six-month period preceding her revocation and concluded Dr. Brown recognized high-risk obstetrics patients and obtained appropriate consultation when necessary. Dr. Lindley also testified the peer review panel's review of only two charts prior to revoking Dr. Brown's obstetrical privileges was unreasonably narrow and did not provide a reasonable basis for concluding Dr. Brown posed a threat to patient safety.

Thus, from Dr. Lindley's testimony, a reasonable jury could have found the panel's review to be unreasonably restrictive and not taken after a "reasonable effort to obtain the facts." Such a finding removes the defendants from the qualified immunity provided by the Health Care Quality Improvement Act. Hence, we conclude the district court did not err in failing to find Presbyterian Healthcare Services, Ms. Miller and Dr. Williams immune, as a matter of law, from damages stemming from the revocation of Dr. Brown's obstetrical privileges.[9]

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[9] The defendants appear to argue the testimony of Dr. Lindley is irrelevant because the defendants presented evidence from a number of doctors who testified the review panel's actions satisfied the requirements of 42 U.S.C. § 11112(a). According to the defendants, "a difference of opinion among experts" does not raise an issue as to the objective reasonableness of the inquiry. We are not persuaded by the

Next, Ms. Miller argues the district court erred in failing to find her immune, as a matter of law, from damages on Dr. Brown's defamation claim. The Health Care Quality Improvement Act confers immunity on any person who makes a report to the National Practitioner Data Bank "without knowledge of the falsity of the information contained in the report." 42 U.S.C. § 11137(c) (1994). Thus, immunity for reporting exists as a matter of law unless there is sufficient evidence for a jury to conclude the report was false and the reporting party knew it was false.

Although the data bank report in this case listed the reason for Lincoln County Medical Center's disciplinary

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defendant's view. Under its theory, a peer review participant would be absolutely immune from liability for its actions so long as it produced a single expert to testify the requirements of 42 U.S.C. § 11112(a) were satisfied. This would be in direct contravention to Congress' intention to provide "qualified immunity." Moreover, to remove a plaintiff's claims from the jury simply because "a difference of opinion among experts" exists would abrogate the jury's responsibility to weigh the evidence and determine the credibility of witnesses. *See, e.g., Moe v. Avions Marcel Dassault-Breguet Aviation*, 727 F.2d 917, 930 (10th Cir.) ("entire jury system is anchored to the jurors' determination of credibility of witnesses and the weight to be given their testimony"), *cert. denied*, 469 U.S. 853 (1984). Thus, in determining whether a peer review participant is immune under the Health Care Quality Improvement Act, the proper inquiry for the court is whether Dr. Brown has provided sufficient evidence to permit a jury to find she has overcome, by a preponderance of the evidence, any of the four statutory elements required for immunity under 42 U.S.C. § 11112(a). *See, e.g., Austin*, 979 F.2d at 734. In this case, we believe Dr. Brown presented sufficient evidence to overcome the presumption and allow the issue to be decided by the jury.

action as "negligence/incompetence/malpractice," the record reveals neither the review panel nor the hospital's Board of Trustees ever found Dr. Brown negligent, incompetent or guilty of malpractice. Rather, the review panel merely determined Dr. Brown breached her agreement to obtain appropriate consultation. Although the panel members were "concerned that [Dr. Brown] does not recognize complicated obstetrics or is reluctant to refer such cases," the panel "felt that Dr. Brown was competent to do uncomplicated obstetrics." Ms. Miller, who was involved in the preparation and review of the report, received a copy of the committee's written findings and was fully aware of the committee's conclusions and the Board of Trustee's action against Dr. Brown. Thus, the record contains sufficient evidence from which a reasonable jury could have concluded the data bank report was false and Ms. Miller knew of its falsity. We therefore affirm the district court's determination Ms. Miller is not immune from defamation damages, as a matter of law, under the Health Care Quality Improvement Act.

Presbyterian Healthcare Services, Ms. Miller and Dr. Williams also claim the district court erred in failing to enter judgment as a matter of law in their favor on the merits of Dr. Brown's antitrust claims. The jury in this case determined Ms. Miller and Dr. Williams joined in a conspiracy to exclude Dr. Brown from competing in the Ruidoso, New Mexico, market. However, the jury did not conclude Presbyterian Healthcare Services participated in the conspiracy. Since the decision to revoke Dr. Brown's medical privileges was made by an independent, nonconspirator (Lincoln County Medical Center's Board of Trustees), the defendants contend Ms. Miller and Dr.

Williams could not have proximately caused the revocation and, therefore, cannot be held liable for Dr. Brown's injuries.

A private plaintiff seeking to invoke the antitrust laws must show the defendants caused her alleged injury. *Todorov v. DCH Healthcare Authority*, 921 F.2d 1438, 1459 (11th Cir. 1991) (citing *Cargill, Inc. v. Monfort of Colo., Inc.*, 479 U.S. 104 (1986)). The key question in determining the defendants' ability to "cause a restraint [of trade] to be imposed" is whether the defendants had control over the decisionmaking process, or the ability to coerce or unduly influence the decision. *See Oksanen v. Page Memorial Hosp.*, 945 F.2d 696, 705-06 (4th Cir. 1991) (medical staff had no control where Board of Trustees requested and encouraged medical staff to take corrective action), *cert. denied*, 502 U.S. 1074 (1992); *Weiss v. York Hosp.*, 745 F.2d 786, 819 n. 57 (3d Cir. 1984) (given dominant role of medical staff and limited nature of review, evidence supported jury's finding medical staff violated antitrust laws), *cert. denied*, 470 U.S. 1060 (1985); *Islami v. Covenant Medical Center, Inc.*, 822 F.Supp. 1361, 1383 (N.D. Iowa 1992) (medical staff had ability to coerce or unduly influence decision). Where a reasonable jury could conclude from the evidence that the defendants controlled, coerced, or unduly influenced the decision that resulted in a restraint of trade, a genuine issue of material fact exists on the issue of causation. *Oksanen*, 945 F.2d at 705-06; *Weiss*, 745 F.2d at 819 n. 57; *Islami*, 822 F.Supp. at 1383.

Here, neither Ms. Miller nor Dr. Williams voted on the decision to revoke Dr. Brown's obstetrical privileges. However, the record reveals both Ms. Miller and Dr. Williams played an influential role in bringing about the

revocation. The jury heard evidence at trial which tended to show Dr. Williams, a competitor of Dr. Brown, and Teresa McCallum, a nurse who had made anti-semitic remarks about Dr. Brown in Dr. Williams' presence, were responsible for identifying all five of Dr. Brown's charts that were reviewed during the two peer review proceedings. Dr. Williams authored the criticisms that Ms. Miller sent to the outside reviewing physicians, and she testified against Dr. Brown at the revocation peer review proceeding. Ms. Miller asked Dr. Williams to prepare the summary of criticisms that were attached to the cases sent to the outside reviewing physicians even though Dr. Brown had complained to Ms. Miller about a personality conflict between Dr. Williams and Dr. Brown. Furthermore, Ms. Miller instituted the formal peer review proceedings against Dr. Brown by sending a complaint to the Medical Staff Executive Committee, she presented the "hospital's position" at the formal review proceeding, and she served on the Board of Trustees.

Thus, the record is replete with evidence tending to show Ms. Miller and Dr. Williams were the catalysts behind, or played a crucial role in, every step of the proceedings against Dr. Brown. Viewing the entire evidence in the light most favorable to Dr. Brown, we believe a reasonable jury could have concluded Dr. Williams and Dr. Brown controlled, coerced or unduly influenced the decisionmaking process. We therefore affirm the district court's denial of the defendants' motion for judgment as a matter of law on the merits of Dr. Brown's antitrust claims.

Finally, Ms. Miller argues the district court erred in failing to grant judgment as a matter of law in her favor

on the merits of Dr. Brown's defamation claim. According to Ms. Miller, Dr. Brown failed to establish the data bank report caused actual injury to her reputation. Under New Mexico law, a plaintiff must prove actual injury to state a claim for defamation; damages cannot be presumed in a defamation action. *Newberry v. Allied Stores, Inc.*, 773 P.2d 1231, 1236 (N.M. 1989) (citing *Poorbaugh v. Mullen*, 99 N.M. 11, 653 P.2d 511, 520 (N.M. Ct. App.), *cert. denied*, 653 P.2d 878 (N.M. 1982)). However, actual injury is not limited to out-of-pocket loss. *Id.*; *see also Cowan v. Powell*, 856 P.2d 251, 253 (N.M. Ct. App.1993). As stated by the New Mexico Supreme Court in *Newberry*, "the more customary types of actual harm inflicted by defamatory falsehood include impairment of reputation and standing in the community, personal humiliation, and mental anguish and suffering." 773 P.2d at 1236 (quoting *Marchiondo v. Brown*, 649 P.2d 462, 470 (N.M. 1982)).

In the case at bar, the record reveals Dr. Brown sought to obtain obstetrical privileges at Gerald Champion Memorial Hospital after the revocation by Lincoln County Medical Center. Pursuant to federal regulations, every hospital that receives an application for clinical privileges must check with the National Practitioner Data Bank for reports on the applicant. 45 C.F.R. § 60.10(a)(1) (1995). Thus, as part of the application process at Gerald Champion Memorial Hospital, Dr. Brown had to undergo a hearing and explain the reason Lincoln County Medical Center revoked her obstetrical privileges. As the district court found, we believe sufficient evidence exists for a jury to have concluded Dr. Brown suffered impairment of reputation and standing in the community or personal humiliation when she had to explain why Lincoln County Medical Center

revoked her privileges based on "negligence/incompetence/malpractice." Although Gerald Champion Memorial Hospital ultimately granted obstetrical privileges to Dr. Brown, "an opportunity for rebuttal seldom suffices to undo harm [sic] of defamatory falsehood." *See Gertz v. Robert Welch, Inc.*, 418 U.S. 323, 344 n. 9 (1974). We therefore affirm the district court's decision to deny the defendants' motion for judgment as a matter of law on the merits of Dr. Brown's defamation claim.

V. Conclusion

For the reasons stated above, we **REVERSE** the district court's order and judgment vacating the jury's award of compensatory and punitive damages on Dr. Brown's tortious interference with contract claim. We **AFFIRM** the judgment of the district court in all other respects.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO

ARLENE BROWN, M.D., and
FAMILY PRACTICE ASSOCIATES, P.C.,

Plaintiffs,

vs.

CIV No. 93-0719 JP/WWD

(Filed Oct. 13, 1995)

PRESBYTERIAN HEALTHCARE SERVICES, VALERIE MILLER, SIERRA BLANCA MEDICAL ASSOCIATES, P.A., VICKIE WILLIAMS, D.O., and GARY JACKSON, D.O.,

Defendants.

MEMORANDUM OPINION AND ORDER

The subjects of this Memorandum Opinion and Order are: (1) defendants' Motion for Judgment as a Matter of Law or to Alter or Amend the Judgment or for a New Trial ("defendants' motion") (doc. #156), filed May 5, 1995; and (2) plaintiffs' Motion for Prejudgment Interest (doc. #153), filed May 2, 1995. At a hearing held July 31, 1995, counsel presented argument on defendants' motion. Defendants were represented by Bruce Hall, Edward Ricco and Theresa Parrish; plaintiffs were represented by Tom Bird and Phil Krehbiel. After thorough consideration of the pleadings, law and arguments presented by counsel, I conclude that defendants' motion should be granted in part and denied in part, and that plaintiffs' motion for prejudgment interest should be denied.

Background:

Plaintiffs, Dr. Arlene Brown, a family practitioner in Ruidoso, New Mexico and her corporation, Family Practice Associates, P.C. ("FPA"), sued defendants (a hospital/health-care service corporation, the hospital administrator, and two staff physicians and their medical corporation) alleging violations of Section 1 and Section 2 of the Sherman Act, 15 U.S.C. §§ 1 and 2, and the New Mexico Antitrust Act, and asserting claims under the common law of New Mexico (breach of contract, intentional interference with contractual and prospective contractual business relations, and defamation). Prior to trial, I denied defendants' motion for summary judgment in which they claimed immunity under the federal Health Care Quality Improvement Act ("HCQIA") and under the New Mexico counterpart to the HCQIA for their actions in revoking Dr. Brown's obstetrical privileges and for submitting a report to the National Practioners Data Bank ("Data Bank"). I also denied defendants' motion for summary judgment based on the merits of plaintiffs' antitrust claims.

At the close of plaintiffs' case at trial, I took under advisement defendants' motion for judgment as a matter of law under Rule 50(a) based on immunity arguments and on the merits of plaintiffs' antitrust claims. However, I granted defendants' motion for judgment as a matter of law regarding plaintiffs' claims of prima facie tort and alleged violations of the New Mexico Unfair Trade Practices Act. At the close of all the evidence, defendants renewed their motion for judgment as a matter of law under Rule 50(a), and I denied defendants' motion on all claims except for plaintiffs' allegations that Dr. Beechie

made a defamatory statement. I submitted all of plaintiffs' remaining claims to the jury. On April 7, 1995, after a three week trial, the jury returned a verdict awarding plaintiffs damages on certain of plaintiffs' antitrust and common law claims.[1] On April 19, 1995, I entered Judgment[2] on the jury's verdict.

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[1] In answering a special verdict form, the jury found that defendants Valerie Miller and Dr. Vickie Williams joined in a conspiracy to exclude plaintiffs from the relevant market in violation of antitrust laws. The jury also determined that Ms. Miller and Dr. Williams conspired to monopolize power in a segment of commerce with the specific intent to achieve that power. Regarding plaintiffs' common law claims, the jury decided that only Presbyterian Healthcare Services ("PHS") intentionally interfered with the performance of a contract or the formation of a prospective contract by plaintiffs, and the jury found that Ms. Miller and Teresa McCallum, a non-defendant, had defamed Dr. Brown. The jury awarded $112,000.00 for plaintiffs' antitrust claims, $7,500.00 for plaintiffs' claims of intentional interference with contractual relations, and $30,000.00 for plaintiffs' claims of defamation against Ms. Miller. In addition, the jury awarded punitive damages of $75,000.00 against PHS for plaintiffs' intentional interference with contractual relations claim, punitive damages of $75,000.00 against Ms. Miller for plaintiffs' antitrust and defamation claims and punitive damages of $75,000.00 against Dr. Williams for plaintiffs' antitrust claims. The jury found in favor of defendants Gary Jackson and Sierra Blanca Medical Associates as to plaintiffs' claims against them.

[2] In the Judgment, I ordered that plaintiffs were entitled to recover from Ms. Miller and Dr. Williams, jointly and severally, the sum of $112,000.00 trebled according to law for a total of $336,000.00. I ordered that plaintiffs should recover from defendant PHS the sum of $7,500.00 compensatory damages and $75,000.00 punitive damages for a total of $82,500.00. I ordered that plaintiffs were to recover from Ms. Miller the sum of $30,000.00 compensatory damages and $75,000.00 punitive

I. **Defendants' Rule 50(b) and Rule 59(e) motion:**

A. Legal standard under Rule 50(b) of the Federal Rules of Civil Procedure:

The standard for granting judgment as a matter of law under Rule 50(b) is identical to the standards for granting a directed verdict or judgment as a matter of law under Rule 50(a) and for granting summary judgment under Rule 56. *Pendleton v. Conoco Inc.*, 23 F.3d 281, 286 (10th Cir. 1994). In other words, the granting of judgment as a matter of law after a jury verdict is not appropriate unless it would have been proper for the court to grant judgment as a matter of law prior to the verdict. In considering a motion under Rule 50(b), a court must determine "whether there is evidence upon which the jury could properly find a verdict for the party against whom the motion is directed." *Aguinaga v. United Food and Commercial Workers International Union*, 993 F.2d 1463, 1469 (10th Cir. 1993) (citation omitted), *cert. denied*, 114 S.Ct. 880 (1994). The court must view the evidence and inferences in the light most favorable to the non-moving party. *Id.* "A motion for [judgment as a matter of law] is properly granted 'only if the evidence points but one way and is susceptible to no reasonable inference which may support the opposing party's position.' " *Id.* (citing *O.E.R., Inc. v. Hickerson*, 880 F.2d 1178, 1180 (10th Cir. 1989)). Under Rule 50(b), if I find that the evidence was

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damages for a total of $105,000.00. Finally, I decreed that plaintiff should recover the sum of $75,000.00 punitive damages from Dr. Williams. I also decreed that plaintiffs' claims against defendants Gary Jackson and Sierra Blanca Medical Associates be dismissed.

insufficient to support the verdict, I may order judgment for the moving party, grant a new trial or order dismissal without prejudice. 5A *Moore's Federal Practice* ¶ 50.11 (2d ed. 1995).

Defendants make the following arguments in favor of their motion for judgment as a matter of law under Rule 50(b): (1) the issue of HCQIA should not have been presented to the jury because sufficient evidence existed to satisfy the objective reasonableness standard of HCQIA immunity and the evidence was insufficient to support the jury's negative responses to the special interrogatories on immunity; consequently, defendants are entitled to immunity from damages arising out of the revocation of Dr. Brown's obstetrical privileges; (2) the evidence was insufficient to show that the hospital's report to the National Practitioner Data Bank was false or that Ms. Miller had actual knowledge of falsity regarding the report and, therefore, defendants are entitled to immunity from damages for the reporting of the peer review action to the Data Bank: (3) the facts found by the jury do not support a judgment against Ms. Miller and Dr. Williams on the antitrust conspiracy claims: (4) there is insufficient evidence to establish liability on the part of Ms. Miller for defamation based on the data bank report; and (5) there is insufficient evidence to establish liability on the part of defendant Presbyterian Healthcare Services ("PHS") for intentional interference with contractual relations.

1. Immunity under the HCQIA for revocation of Dr. Brown's obstetrical privileges:

At the summary judgment stage, I determined that plaintiffs had submitted sufficient evidence, which if believed by a jury, would show by a preponderance of the evidence that defendants acted outside the scope of § 11112(a) of the HCQIA.[3] Specifically, I decided that plaintiffs had raised a genuine issue of material fact regarding whether defendants had complied with standards (1), (2), and (4) of § 11112(a).[4] During trial, at the close of all the evidence, I again concluded that there were disputed subsidiary issues of fact concerning standards (1), (2) and (4) of § 11112(a). Accordingly, in the form of special interrogatories, I presented three questions to the jury asking (1) whether the defendants reasonably believed that their action was in furtherance of

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[3] To qualify for immunity under the HCQIA, the action taken by a peer review body must be made according to all of the following four standards:

> (1) in the reasonable belief that the action was in furtherance of quality health care,
>
> (2) after a reasonable effort to obtain the facts of the matter,
>
> (3) after adequate notice and hearing procedures . . . , and
>
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

42 U.S.C. § 11112(a).

[4] Plaintiffs did not contend that defendants failed to provide them with adequate notice or procedures under standard (3) of § 11112(a).

quality health care, (2) whether the action came after a reasonable effort to obtain the facts of the matter, and (3) whether the defendants reasonably believed that the action was warranted by the facts known after such reasonable effort to obtain the facts. *See* 42 U.S.C. § 11112(a)(1),(2),(4). The jury answered "no" to each of these three questions.

In their post-trial motion, defendants first argue that the court incorrectly presented the ultimate question of HCQIA immunity to the jury by treating the statutory elements as questions of fact to be answered in the form of special interrogatories. Next, defendants assert that the testimony at trial was sufficient to satisfy the objective reasonableness standard contained in § 11112(a) and that there was insufficient evidence to support the jury's negative responses to the special interrogatories on immunity.

a. submission of disputed subsidiary facts concerning HCQIA immunity to jury:

Generally, the issue of HCQIA immunity from damages is a question for the court to resolve at the summary judgment stage or during trial before the submission of plaintiffs' claims to the jury. *Bryan v. James E. Holmes Regional Medical Center*, 33 F.3d 1318, 1332 (11th Cir. 1994), *cert. denied*, 115 S. Ct. 1363 (1995). However, a court may decide the issue when raised by a post-trial motion. *Id.* In examining a motion under Rule 50(b), the court's inquiry should focus on whether plaintiff "provided sufficient evidence to permit a jury to find that [plaintiff] ha[d]

overcome, by a preponderance of the evidence, the presumption that [the Hospital] would reasonably have believed that it had met the standards of section 11112(a) [of the HCQIA]." *Id.* at 1334 (quoting *Austin v. McNamara*, 979 F.2d 728, 734 (9th Cir. 1992)).

If a court is unable to determine prior to submitting plaintiffs' claims to the jury whether defendants are entitled to HCQIA immunity, "then the merits of the case should be submitted to the jury without reference to the immunity issue. If there are disputed subsidiary issues of fact concerning HCQIA immunity, such as whether the disciplined physician was given adequate notice of the charges and the appropriate opportunity to be heard, the court may ask the jury to resolve the subsidiary factual questions by responding to special interrogatories." *Bryan*, 33 F.3d at 1333. Under *Bryan*, therefore, it was appropriate to ask the jury to answer unresolved subsidiary factual questions by responding to special interrogatories.

b. sufficiency of evidence regarding inquiry under HCQIA of objective reasonableness:

The HCQIA was intended "not to disturb, but to reinforce, the preexisting reluctance of courts to substitute their judgment on the merits for that of health care professionals and of the governing bodies of hospitals in an area within their expertise." *Bryan*, 33 F.3d at 1337 (citation omitted). However, at least one court has stated that "these considerations cannot justify the judiciary in

pretermitting consideration of the application of the antitrust laws to the health care field, particularly now that the provision of health services is becoming increasingly concentrated and the opportunities for physicians more limited." *Brader v. Allegheny General Hosp.*, 64 F.3d 869, ___ (3d Cir. 1995).

I note that the inquiry under the HCQIA is one of objective reasonableness and that Congress, in adopting the HCQIA, initially considered a subjective standard which it ultimately rejected in favor of a higher objective standard. Additionally, it is clear that the HCQIA establishes a statutory presumption in favor of finding that the professional review action has met the standards set out under § 11112(a) unless plaintiff rebuts the presumption by a preponderance of the evidence. 42 U.S.C. § 11112(a).

On the basis of the evidence and testimony, I conclude that the evidence does not "point but one way" and that there are reasonable inferences that would support the jury's answers to the special interrogatories. PHS's medical peer review committee revoked Dr. Brown's obstetrical privileges on the basis of two patients' charts. It was disputed whether Dr. Brown violated the requirement to obtain a consultation in high risk pregnancies in those two cases. Plaintiffs' expert, Dr. Lindley, testified that he did not think Dr. Brown had violated the consultation requirement in her treatment of those two patients. In addition, Dr. Fellows, an obstetrician who served on the privileges panel at Gerald Champion Memorial Hospital in Alamogordo, New Mexico testified that after looking at the two cases on which defendants based their decision to revoke Dr. Brown's obstetrical privileges, he believed Dr. Brown had abided with the consultation

requirement. Furthermore, Dr. Lindley testified that he believed a decision to revoke obstetrical privileges should be based on a more representative sample of the physician's charts which are selected over, for example, a six month period. "I felt that based on the two charts that were reviewed by [the hospital's peer review committee] that I did not come to the conclusion that [Dr. Brown] was a threat to anybody's safety on this basis, and that is why I felt that [the hospital's peer review committee] couldn't either." Transcript Mar. 23, 1995 at 71, 160. Dr. Lindley also stated that he believed the charts reviewed by the hospital's committee were hand-picked.

The majority of cases in which courts have found that HCQIA immunity was proper involved a much more extensive and well-documented review of the physician's charts. In a recently decided case, the court granted HCQIA immunity to defendants on a motion for summary judgment finding that plaintiff had failed to defeat the presumption that defendants had complied with the requirements of § 11112(a). *Mathews v. Lancaster General Hospital, et al.*, 883 F. Supp. 1016, 1035 (E.D. Penn. 1995). However, the court in *Mathews* noted that the review of the plaintiff physician's record was comprehensive. The review of one of the physicians who was suspended had encompassed 208 cases and had taken two years. After examining the 208 cases, the reviewing committee concluded that 27 of that doctor's cases were substandard. *Id.* at 1021. During the course of that same review, the committee also discovered the plaintiff physician had participated in the medical care of the patient in nearly each of the 27 substandard care cases. The committee found that plaintiff physician's medical care was deficient

in 23 of 27 cases. *Id.* For a more lengthy discussion of the cases involving HCQIA immunity, see this Court's Memorandum Opinion and Order entered March 3, 1995, at pp. 20-24.

I also note that while the statutory language of the HCQIA under standards (1) and (4) of § 11112(a) requires the professional review action to be taken "in the *reasonable belief*" (emphasis added) that the action was in the furtherance of quality health care and that the action was warranted by the facts, the statute omits "taken in the reasonable belief" as to standard (2). Standard (2) of § 11112(a) merely states that the action must be taken "after a reasonable effort to obtain the facts of the matter." Therefore, the test under standard (2) is not whether the committee *believed* its effort to obtain the facts was reasonable. Rather, the inquiry focusses on whether the committee's effort was objectively reasonable.

After viewing the evidence, testimony, and inferences in the light most favorable to the non-moving party, I conclude that plaintiffs presented "sufficient evidence to permit a jury to find that [plaintiffs] ha[d] overcome, by a preponderance of the evidence, the presumption that [the Hospital] would reasonably have believed that it had met the standards of section 11112(a) [of the HCQIA]." *Bryan*, 33 F.3d at 1334 (citation omitted). I also decide that there was evidence to support the jury's negative responses to the special interrogatories on HCQIA immunity. Therefore, defendants' motion for judgment as a matter of law under Rule 50(b) on the issue of HCQIA immunity for the peer review committee's action of revoking Dr. Brown's obstetrical privileges should be denied.

2. Immunity under the HCQIA for the reporting of the peer review action to the Data Bank:

The HCQIA provides immunity from damages to a person or entity who makes a report of a peer review committee's action to the Data Bank unless the person making the report had knowledge of false information in the report. 42 U.S.C. § 11137(c). Defendants argue that plaintiffs presented insufficient evidence to support a finding that the report to the data bank report contained false information or that the person making the report had knowledge of any false information in the report.

At trial, plaintiffs presented evidence that Glenda Perry, a PHS employee, under the supervision of Ms. Miller, submitted a report to the Data Bank. Ms. Perry selected a code for the report that indicated the hospital had revoked Dr. Brown's privileges due to "negligence/incompetence/malpractice." It is undisputed that Ms. Perry chose this code after the peer review committee had decided that Dr. Brown had failed in two cases to comply with her consultation requirement. However, plaintiffs showed that Ms. Perry had attended the peer review proceedings and did not believe that the "negligence/incompetence/malpractice" code fit Dr. Brown's situation. Ms. Perry testified that she was uncomfortable with the selection of this code and did not believe that the Board had decided Dr. Brown was negligent or incompetent or that Dr. Brown had committed malpractice. Ms. Perry stated that she looked up the word "negligence" in a dictionary and believed that the code containing the word "negligence" was the one that came closest to describing Dr. Brown's situation.

Ms. Perry also testified that when she informed her supervisor, Ms. Miller, of her concern with the code "negligence/incompetence/malpractice," Ms. Miller told her to just make sure it's right. Once PHS submitted the report to the Data Bank, a copy of the report was sent to Dr. Brown. Dr. Brown disputed the code that PHS had selected, and the Data Bank asked PHS whether it wished to change the code designation. PHS elected to keep the same code designation of "negligence/incompetence/malpractice." Plaintiffs showed that Ms. Perry could have selected the code description "other," although Ms. Perry stated that she did not consider "other" to be appropriate.

In addition, the evidence demonstrated that Ms. Miller had been present at the review proceedings and that none of the review participants had discussed negligence, incompetence or acts of malpractice by Dr. Brown. Ms. Miller testified that the hospital interpreted the "negligence/incompetence/malpractice" code in the disjunctive and that she felt the term "negligence" best fit the situation. Plaintiffs' evidence showed that prior to Ms. Perry's submission of the Data Bank report, Ms. Miller had received a letter from Mr. W. Robert Lasater, Lincoln County Medical Center's ("LCMC") attorney, who admitted that PHS did not feel that there was an issue of whether Dr. Brown's actual care was appropriate in a given case. In his letter, Mr. Lasater stated that the issue was whether Dr. Brown had violated her consultation requirement. Also, Gary Mitchell, a member of the Board of Trustees, testified that at its meeting, the Board did not conclude that Dr. Brown had committed negligence or malpractice or that she was incompetent. However, Mr.

Mitchell also testified that he believed Dr. Brown's alleged violation of the consultation requirement related to quality of care concerns and issues of competence or whether Dr. Brown was competent to recognize high risk cases. In addition, Mr. Mitchell stated that this was not a "medical issue," but rather, it was an issue of whether Dr. Brown had kept a promise to obtain a consultation in high risk cases.

Based on the testimony and exhibits presented at trial, I conclude there was sufficient evidence to support the jury's finding that the Data Bank report contained false information or that Ms. Miller had knowledge of false information contained in the report. Therefore, defendants' motion for judgment as a matter of law under Rule 50(b) based on its immunity for the hospital's report to the Data Bank should be denied.

3. Judgment against Ms. Miller and Dr. Williams on the antitrust conspiracy claims:

In the special verdict form, the jury determined that only Ms. Miller and Dr. Williams conspired together in restraint of trade and to obtain or maintain monopoly power in a segment of commerce. The jury did not find that PHS, Sierra Blanca Medical Associates, P.A. or Dr. Gary Jackson participated in antitrust conspiracies. Defendants argue first that a conspiracy between Ms. Miller and Dr. Williams could not have existed as a matter of law because Ms. Miller and Dr. Williams, as agents of the hospital, lacked the legal capacity to conspire. Further, Ms. Miller and Dr. Williams did not vote

on the decision to revoke Dr. Brown's obstetrical privileges and so, could not have conspired to influence the decision. Next, defendants argue that even if a conspiracy between Ms. Miller and Dr. Williams is cognizable as a matter of law, such a conspiracy could not have caused plaintiffs' injury as a matter of fact. Defendants contend that the hospital's Board of Trustees independently made the decision to revoke Dr. Brown's obstetrical privileges. Neither Ms. Miller nor Dr. Williams cast a vote.

a. legal capacity to conspire:

To establish a violation of the Sherman Act, a plaintiff must show proof of a concerted action involving two or more entities that are legally capable of conspiring. *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752, 768 (1984). Under the intracorporate conspiracy doctrine, a corporation cannot ordinarily conspire with its agents or employees because the corporation and its staff are viewed as a single entity. *Nurse Midwifery Associates v. B.K. Hibbett, M.D.*, 918 F.2d 605, 612 (6th Cir. 1990), *cert. denied*, 502 U.S. 952 (1991). *See Oksanen v. Page Memorial Hosp.*, 945 F.2d 696, 702-05 (4th Cir. 1991) (en banc) (hospital is incapable of conspiring with its medical staff during the peer review process when the functional relationship between them is analogous to that of corporation and its agent), *cert. denied*, 502 U.S. 1074 (1992).

Some courts have recognized that "a hospital's medical staff are more than 'agents' of the hospital for antitrust purposes," *Nurse Midwifery*, 918 F.2d at 612, because

a medical staff member may have a personal or independent economic stake in making privilege recommendations concerning a competitor. *Todorov v. DCH Healthcare Auth.*, 921 F.2d 1438 (11th Cir. 1991); *Oltz v. St. Peter's Community Hosp.*, 861 F.2d 1440, 1450 (9th Cir. 1988). If a member of a hospital's staff could act with an independent and competing interest, the medical staff member and the hospital would not be treated as a single entity and could have the legal capacity to conspire. *Bolt v. Halifax Hosp. Medical Ctr.*, 891 F.2d 810, 819 (11th Cir.), *cert. denied*, 495 U.S. 924 (1990).

Here, I already determined, as a matter of law, that the "personal stake" exception applies when the physicians or employees in a hospital or corporation are shown to have independent and competing economic interests. In such circumstances, a hospital could conspire with its physicians or employees. Although the Tenth Circuit Court of Appeals has not decided this exact issue, it has indicated a willingness to recognize the "personal stake" exception in the franchisor-franchisee context. *Motive Parts Warehouse v. Facet Enterprises*, 774 F.2d 380, 387-88 (10th Cir. 1985). More recently, the Tenth Circuit has decided that the "personal stake" exception should apply in the civil rights area. *Brever v. Rockwell International Corp.*, 40 F.3d 1119, 1127 (10th Cir. 1994) ("In these situations, the action by an incorporated collection of individuals creates the 'group danger' at which conspiracy liability is aimed, and the view of the corporation as a single legal actor becomes a fiction without a purpose.") (citation omitted).

Plaintiffs presented evidence at trial that Ms. Miller was the administrator and an employee of Lincoln

County Medical Center. There was no evidence that Ms. Miller acted outside her position as an employee of LCMC and PHS. Therefore, the jury could have concluded that Ms. Miller was acting, at all times pertinent to this lawsuit, as an agent of PHS. *See Court's Instructions to the Jury No. 48* ("Any act of an agent or an employee of a corporation, within the scope or course of his or her agency or employment, is the act of the corporation.") In addition, Mr. Barr, the CEO of PHS, testified that PHS had already decided to indemnify the defendants because PHS believed that the defendants had acted properly and in good faith.

The evidence demonstrated that Dr. Williams was on the medical staff of LCMC, and also was an owner, with her husband Dr. Jackson, of another entity, defendant Sierra Blanca Medical Associates. Plaintiffs presented testimony that Dr. Williams and Sierra Blanca Medical Associates competed with Dr. Brown for obstetrics patients. I have already concluded as a matter of law that a hospital and its medical staff may be considered separate entities that are capable of conspiring with one another. Ms. Miller, as an agent of PHS, could be viewed as one entity and Dr. Williams, a financial competitor of Dr. Brown's, could be considered another entity. *See Bolt*, 891 F.2d at 819 ("A hospital and the members of its medical staff, . . . are legally separate entities . . . "). Therefore, I conclude that the Miller-Williams conspiracy is cognizable as a matter of law.

b. causation:

Defendants argue that even if the "personal stake" exception is recognized as a matter of law, it is inapplicable where the agent with the independent interest "cannot cause a restraint to be imposed." *Oksanen*, 945 F.2d at 705; *Willman v. Heartland Hosp. East*, 836 F. Supp. 1522, 1528-29 (W.D. Mo. 1993) (hospital had final say and defendant staff members lacked power to sway vote), *aff'd*, 34 F.3d 605 (8th Cir. 1994), *cert. denied*, 115 S.Ct. 1361 (1995).

The court in *Islami v. Covenant Medical Center, Inc.*, 822 F. Supp. 1361, 1383 (N.D. Iowa 1992), found that the key question in examining the medical staff's ability to "cause a restraint to be imposed" is whether the medical staff had the ability to coerce or unduly influence the decision. *Citing Weiss v. York Hosp.*, 745 F.2d 786, 819 n.57 (1984), *cert. denied*, 470 U.S. 1060 (1985) and P. Areeda, *Antitrust Law*, ¶ 1471(h).

Here, it is undisputed that Ms. Miller and Dr. Williams did not vote on the decision to revoke Dr. Brown's obstetrical privileges. Although the Board of Trustees made the final decision to revoke Dr. Brown's obstetrical privileges, Ms. Miller served on the Board and was present during most of the peer review process. Ms. Miller was also aware that Dr. Brown was concerned about a personality conflict between Dr. Brown and Dr. Williams and that Dr. Brown did not want Dr. Williams involved in any review of Dr. Brown's cases. Plaintiffs presented evidence at trial showing that Dr. Williams, a competitor of Dr. Brown's and Teresa McCallum, a nurse who had

made anti-semitic remarks about Dr. Brown in Dr. Williams' presence, were responsible for identifying perhaps as many as all five of Dr. Brown's files that the hospital reviewed. Dr. Williams also testified that she authored the initial reviewing committee's concerns and criticisms regarding Dr. Brown's care in the first three cases that were tagged for review. Dr. Williams' commentaries accompanied the three cases sent to outside reviewing physicians. Dr. Williams also testified against Dr. Brown at the formal peer review proceeding.

After viewing all of the testimony and inferences in the light most favorable to plaintiffs, I conclude that sufficient evidence supported the jury's verdict for plaintiffs on the issue of whether the conspiracy between Ms. Miller and Dr. Williams proximately caused the plaintiffs' damages. Therefore, defendants' motion for judgment as a matter of law under Rule 50(b) on the issue of plaintiffs' antitrust claims[5] should be denied.

4. Liability of Ms. Miller for defamation:

The parties agree that Dr. Brown's recovery for defamation rests solely on the Data Bank report. *See* discussion *supra*. Plaintiffs have the burden of proving that a defamatory communication was a proximate cause of *actual injury* to her reputation. *See Court's Instructions to*

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[5] I note that in their post-trial motion defendants challenge only the issues of legal capacity to conspire and causation and do not argue that plaintiffs failed to present sufficient evidence showing that the members of the conspiracy actually did conspire. Therefore, I do not address that argument.

the Jury No. 14; SCRA 1986 13-1002 (emphasis added). "Suffice it to say that actual injury is not limited to out-of-pocket loss. Indeed, the more customary types of actual harm inflicted by defamatory falsehood include impairment of reputation and standing in the community, personal humiliation, and mental anguish and suffering." *Newberry v. Allied Stores, Inc.*, 108 N.M. 424, 429 (1989).

Plaintiffs presented testimony at trial that after PHS revoked Dr. Brown's obstetrical privileges, Dr. Brown believed she needed to find other locations where she could perform deliveries in order to maintain her competency. Every hospital that receives an application for clinical privileges must check with the Data Bank for reports on the applicant. 45 C.F.R. § 60.10(a)(1). Dr. Brown applied at Gerald Champion Memorial Hospital in Alamogordo and was also given privileges there. However, Dr. Brown first had to explain why LCMC had revoked her obstetrical privileges, and she had to undergo a hearing process defending her application for privileges at Gerald Champion. Dr. Brown also testified that she applied for and received obstetrical privileges at William Beaumont Hospital in El Paso, Texas. Again, in any application for obstetrical privileges, Dr. Brown would need to explain the revocation of privileges and the code that LCMC submitted to the Data Bank.

Sufficient evidence exists for a jury to have concluded that Dr. Brown suffered impairment of reputation and standing in the community or personal humiliation when she had to explain why LCMC had revoked her privileges at the times she applied for privileges at other hospitals. Therefore, defendants' motion for judgment as

a matter of law under Rule 50(b) on plaintiffs' defamation claim against Ms. Miller should be denied.

5. Liability of PHS for intentional interference with contractual relations:

Defendants' argument that PHS should not be held liable for intentional interference with contractual relations involving the recruitment of Dr. Rieb is threefold: (a) there was insufficient evidence to establish with certainty an award of damages; (b) there was insufficient evidence to show that defendants acted with improper means or an improper purpose; and (c) there was insufficient proof that any conduct by PHS actually caused injury to plaintiffs.

Because I conclude that plaintiffs have failed to present adequate proof of actual damages under the intentional interference claim, I need not address defendants' remaining arguments. Plaintiffs bear the burden of proving damages for an intentional interference claim with a reasonable degree of certainty. *Lightning Lube, Inc. v. Witco Corp.*, 4 F.3d 1153, 1176 (3rd Cir. 1993). "Liability under a tortious interference theory cannot be predicated upon speculation, conjecture, or guesswork. . . . " *Mueller v. Abdnor*, 972 F.2d 931, 938 (8th Cir. 1992).

At trial, plaintiffs' expert, Dr. M. Brian McDonald, Ph.D., presented projections of Dr. Brown's and FPA's damages. Dr. McDonald first analyzed plaintiffs' actual patient receipts over a period of years. Then Dr. McDonald set forth three different projections of damages for plaintiffs, assuming that patient receipts either should have grown 20 percent, 30 percent or 40 percent. Dr.

McDonald explained that one factor justifying the higher projections was Dr. McDonald's understanding that PHS prevented Dr. Brown from adding additional health care practitioners to her business. Partial Transcr. March 27, 1995 at p. 70. "If Dr. Brown and FPA were able to add additional health care practitioners, they would be able to increase their patient receipts from that additional health care practitioner, and they would be able to do it more if they brought them in as an employee." *Id.* at p. 70. Dr. McDonald gave specific examples of how much revenue certain FPA employees had generated for the business. However, Dr. McDonald did not separate out any calculations for revenue that was lost by FPA's failure to add additional physicians or health care providers. Apparently, Dr. McDonald included those calculations within the higher 30% and 40% projected revenues for FPA's business.

Although plaintiffs need only prove damages with reasonable certainty, Dr. McDonald's projections, as they relate to the business Dr. Rieb may have brought to FPA, seem speculative at best. Because I decide that there was insufficient evidence to support the jury's verdict awarding plaintiffs $7,500.00 on their claim for intentional interference with contractual relations, I conclude that defendants' motion for judgment as a matter of law under Rule 50(b) on that claim should be granted. Therefore, the award of $7,500.00 against PHS should be set aside. In addition, because the punitive damages award of $75,000.00 against PHS was connected only to the jury's finding that PHS intentionally interfered with

plaintiffs' contractual relations, the punitive damages award of $75,000.00 against PHS should be set aside.[6]

B. Legal standard under Rule 59(e) of the Federal Rules of Civil Procedure:

Rule 50(b) provides that a motion for a new trial under Rule 59 may be joined with the motion for judgment as a matter of law or that a party may move for a new trial in the alternative. A court has the discretion to grant a motion for a new trial under Rule 59 "when the jury verdict is against the weight of the evidence, the damages are excessive, a party was prejudiced by erroneous evidentiary rulings, or the trial was not fair to the moving party." *Megadyne Medial Products, Inc. v. Aspen Laboratories, Inc.*, 864 F. Supp. 1099, 1102 (D. Utah 1994), *aff'd* 52 F.3d 344 (10th Cir. 1995); *see Brown v. McGraw-Edison Co.*, 736 F.2d 609 (10th Cir. 1984) (a motion for a new trial presents a question of fact and not of law whether the verdict is against the weight of the evidence and is addressed to the discretion of the court). The

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[6] The jury did not conclude that PHS was guilty of the antitrust conspiracy claims, and instead, decided that Ms. Miller and Dr. Williams participated in the antitrust conspiracy. Regarding plaintiffs' antitrust claims, I recognize that the jury may have found Ms. Miller was at all times acting as an employee of PHS and that Ms. Miller's acts were the acts of PHS. However, even if the jury based its punitive damages award against PHS on both plaintiffs' antitrust and intentional interference claims, now that I have set aside the award against PHS on plaintiffs' intentional interference claim, a sole remaining antitrust violation by PHS would not support an award of punitive damages against PHS. *See* discussion *infra* at pp. 21-23.

standard for deciding a motion for a new trial is less stringent than the standard controlling a motion for judgment as a matter of law. *Megadyne*, 864 F. Supp. at 1102. Before a court will grant a motion for a new trial, it must find that the jury verdict was "clearly, decidedly or overwhelmingly against the weight of the evidence." *Brown*, 736 F.2d at 616-17. A court should not interfere with the verdict unless it is clear that the jury has reached a seriously erroneous result. *Frank v. Bloom*, 634 F.2d 1245, 1254 (10th Cir. 1980). A court may not order a new trial on the basis that there is a sharp conflict in the evidence. *Jackson v. City of Albuquerque*, 715 F. Supp. 1048, 1050 (D.N.M. 1987), *rev'd in part, on other grounds*, 890 F.2d 225 (10th Cir. 1989). However, if it clearly appears that the jury "has committed a gross error, or has acted from improper motives, or has given damages excessive in relation to the person . . . , it is as much the duty of the court to interfere, to prevent the wrong, as in any other case." *Arkansas Valley Land & Cattle Co. v. Mann*, 130 U.S. 69 (1889). In addition, a motion under Rule 59 allows for the alteration or amendment of a judgment. Civ.R. 59(e).

Defendants make the following arguments in favor of a new trial or modification of the judgment under Rule 59: (1) the jury verdict on the question of HCQIA was against the weight of the evidence; (2) Ms. Miller and Dr. Williams are entitled to a new trial on plaintiffs' antitrust conspiracy claims; and (2) [sic] the award of punitive damages against Dr. Williams should be set aside because punitive damages are not available when damages are trebled for an antitrust violation.

1. Motion for new trial on the issue of HCQIA immunity:

I have already concluded that the ultimate question of HCQIA immunity was not submitted to the jury and that it was proper to present to the jury disputed subsidiary issues of fact regarding HCQIA immunity in the form of special interrogatories. See discussion *supra*. Based on the testimony offered at trial, I do not find that the jury's responses to the special interrogatories are "clearly, decidedly or overwhelmingly against the weight of the evidence." Therefore, defendants' motion for a new trial on the issue of HCQIA immunity should be denied.

2. Motion for new trial on plaintiffs' antitrust conspiracy claims:

Defendants argue that the jury's conclusion that the Miller-Williams conspiracy proximately caused the plaintiffs' injury was decidedly against the weight of the evidence because an independent Board of Trustees made the disciplinary decision. As I discussed, *supra*, Ms. Miller and Dr. Williams were participants in or present during much of the peer review process. A jury reasonably could have concluded that although Ms. Miller and Dr. Williams did not cast a vote, they were in a position to unduly influence the decision, and did so. Because I do not find that the jury has reached a seriously erroneous result which warrants interference with its verdict, I conclude that defendants' motion for a new trial on plaintiffs' antitrust conspiracy claim should be denied.

3. Award of punitive damages against Dr. Williams:

The jury found Dr. Williams liable only on plaintiffs' antitrust conspiracy claims and also awarded punitive damages against Dr. Williams in the amount of $75,000.00. I awarded treble damages regarding the antitrust conspiracy claims as required by 15 U.S.C. § 15(a). Defendants argue that the punitive damages award as to Dr. Williams should be set aside because the treble damages provision of the antitrust laws encompasses both punitive and compensatory damages. Plaintiffs do not appear to dispute the rule that punitive damages cannot be awarded together with trebled damages for an antitrust violation. Instead, plaintiffs contend that defendants' argument is a belated and improper challenge to the jury instructions and special verdict form.

"Punitive damages beyond the statutory trebled damages cannot be awarded for an antitrust violation. The enhancement of damages in an antitrust cases is the damages trebled." *McDonald v. Johnson & Johnson*, 722 F.2d 1370, 1381 (8th Cir. 1983) (citation omitted), *cert. denied*, 469 U.S. 870 (1984). *See also Clark Oil Co. v. Phillips Petroleum Co.*, 148 F.2d 580, 582 (8th Cir.) (treble damage provision encompasses both punitive and compensatory damages), *cert. denied*, 326 U.S. 734 (1945).

I agree with defendants that an award of punitive damages against Dr. Williams would be duplicative because the treble damages provision already embodies punitive damages. I recognize that defendants did not raise an objection to the punitive damage jury instruction or to the punitive damage section of the special verdict

form. However, it would have been impractical and confusing to the jury to have drafted the special verdict to include all of the combinations of circumstances under which punitive damages could or could not have been awarded against various defendants.

Rule 59(e) allows the court considerable discretion in deciding whether to grant or deny a motion to amend or alter the judgment. *Bohlin Co. v. Banning Co.*, 6 F.3d 350, 355 (5th Cir. 1993). A court may grant a motion to amend or alter the judgment if the movant demonstrates that this is necessary to correct manifest errors of law. Wright, Miller & Kane, *Federal Practices and Procedure: Civil 2d* § 2810.1 at p. 124-25.

I conclude that the jury's verdict awarding plaintiffs punitive damages against Dr. Williams was a clearly erroneous result and that it is my duty to correct this aspect of the verdict. Therefore, defendants' motion to modify the judgment under Rule 59(e) as to the punitive damages award against Dr. Williams should be granted and the punitive damages award of $75,000.00 against Dr. Williams should be set aside.

II. Plaintiffs' Motion for Prejudgment Interest:

Plaintiffs seek prejudgment interest on the federal and state law antitrust awards and on the defamation and intentional interference awards. An award of prejudgment interest is within the district court's discretion. *Resolution Trust v. Federal Savings & Loan Insurance Corp.*, 25 F.3d 1493, 1506 (10th Cir. 1994).

A. Prejudgment interest on federal and state law antitrust awards:

Section 15(a) of Title 15 of the United States Code sets forth the legal standard to be applied in deciding whether to award prejudgment interest on a federal antitrust award. This legal standard also controls an award of prejudgment interest on the state antitrust award because state antitrust law is to be construed harmoniously with federal antitrust law. *See Clough v. Adventist Health Systems, Inc.*, 108 N.M. 801 (1989).

> The court may award under this section, pursuant to a motion by such person promptly made, simple interest on actual damages for the period beginning on the date of service of such person's pleading setting forth a claim under the antitrust laws and ending on the date of judgment, or for any shorter period therein, if the court finds that the award of such interest for such period is just in the circumstances. In determining whether an award of interest under this section for any period is just in the circumstances, the court shall consider only –
>
> (1) whether the person or the opposing party, or either party's representative, made motions or asserted claims or defenses so lacking in merit as to show that such party or representative acted intentionally for delay, or otherwise acted in bad faith;
>
> (2) whether, in the course of the action involved, such person or the opposing party, or either party's representative violated any applicable rule, statute, or court order providing for sanctions for dilatory behavior or otherwise providing for expeditious proceedings; and

> (3) whether such person or the opposing party, or either party's representative, engaged in conduct primarily for the purpose of delaying the litigation or increasing the cost thereof.

15 U.S.C. § 15(a).

Congress amended § 15(a) to permit a private antitrust plaintiff to recover prejudgment interest only if the defendant is guilty of unnecessary delay. *Fishman v. Estate of Wirtz*, 807 F.2d 520, 561 (7th Cir. 1986). After considering the factors under § 15(a), I conclude that an award of prejudgment interest on the federal and state antitrust awards is not "just in the circumstances." Clearly, defendants' asserted defenses had merit. As I stated in my March 3, 1995 Memorandum Opinion and Order, several of defendants' defenses to plaintiffs' antitrust claims presented either a "close call" or a "difficult decision." I am not aware of any party in this action who violated an applicable rule, statute or court order. There were no sanctions for dilatory behavior. Neither party appeared to engage in activities for the purpose of delaying the litigation or to increase costs. Therefore, plaintiffs' motion for prejudgment interest on the federal and state law antitrust awards should be denied.

B. Prejudgment interest on plaintiffs' defamation and intentional interference claims:

New Mexico statute § 56-8-4(b) governs the award of prejudgment interest on the state law claims of defamation and intentional interference. *See Eastman Kodak Co. v. Westway Motor Freight, Inc.*, 949 F.2d 317, 321 (10th Cir.

1991) (state law controls prejudgment interest). The purpose of § 56-8-4(b) is to foster settlement and to prevent delay. *Southard v. Fox*, 113 N.M. 774, 778 (Ct. App. 1992). Section 56-8-4(b) provides:

> The court in its discretion may allow interest of up to ten percent from the date the complaint is served upon the defendant after considering among other things:
>
> (1) if the plaintiff was the cause of unreasonable delay in the adjudication of the plaintiff's claims; and
>
> (2) if the defendant had previously made a reasonable and timely offer of settlement to the plaintiff.

N.M.S.A. 1978 § 56-8-4(b) (1995 Cumm. Supp.). Section 56-8-4(b) allows for prejudgment interest in tort claims in addition to contract claims. *Southard*, 113 N.M. at 777.

The New Mexico statute provides the trial court with discretion on the question of whether to award prejudgment interest. The statute lists two nonexclusive factors for the court to consider. *Sunwest Bank of Albuquerque v. Colucci*, 117 N.M. 373, 378 (1994). A court might consider such factors as whether awarding prejudgment interest serves to compensate the injured party or whether the award is otherwise equitable. *See Overbrook Farmers Union v. Missouri Pacific Railroad*, 21 F.3d 360, 366 (10th Cir. 1994).

Here, neither plaintiffs nor defendants caused any unreasonable delays. The case proceeded to trial in a timely fashion. However, plaintiffs argue that defendants never made an offer to settle. In August 1994, the parties attended a settlement conference before United States Magistrate Judge William F. Deaton but defendants did

not make a monetary offer to settle. Both parties agreed that Judge Deaton should cancel the second scheduled settlement conference. Although it is true that defendants never made a monetary offer of settlement, I note that both parties participated in negotiations about a training program that would assist Dr. Brown in restoring her obstetrical privileges. I am also aware that, at times, both parties' efforts to devise an acceptable training program lapsed. Under the circumstances, I believe that an award of prejudgment interest would not be equitable because both parties engaged in reasonable attempts to resolve this dispute even though defendants did not make a monetary offer to settle. Therefore, plaintiffs' motion for prejudgment interest on the state law claims should be denied. IT IS THEREFORE ORDERED that:

(I)(A) In regard to defendants' motion for judgment as a matter of law under Rule 50(b):

(1) on the issue of HCQIA immunity for the peer review committee's action in revoking Dr. Brown's obstetrical privileges, defendants' motion is DENIED;

(2) on the issue of HCQIA immunity for the hospital's report to the Data Bank, defendants' motion is DENIED;

(3) on the issue of plaintiffs' antitrust claims, defendants' motion is DENIED;

(4) on the issue of plaintiffs' defamation claim against Ms. Miller, defendants' motion is DENIED;

(5) on the issue of plaintiffs' claim of intentional interference, defendants' motion is GRANTED, and the compensatory damages award of $7,500.00 against

Presbyterian Healthcare Services is hereby set aside; in addition, the punitive damages award of $75,000.00 against Presbyterian Healthcare Services is set aside.

(I)(B) In regard to defendants' motion for a new trial and for modification of the judgment under Rule 59:

(1) on the issue of HCQIA immunity, defendants' motion is DENIED;

(2) on the issue of plaintiffs' antitrust conspiracy claim, defendants' motion is DENIED;

(3) on the issue the award of punitive damages against Dr. Williams, defendants' motion is GRANTED, and the punitive damages award of $75,000.00 against Dr. Williams is hereby set aside.

(II) Plaintiffs' motion for prejudgment interest is DENIED.

/s/ James A. Parker
UNITED STATES
DISTRICT COURT

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO

ARLENE BROWN, M.D., and
FAMILY PRACTICE ASSOCIATES, P.C.,

Plaintiffs,

vs. CIV No. 93-0719 JP/WWD

(Filed Mar. 3, 1995)

PRESBYTERIAN HEALTHCARE SERVICES, VALERIE MILLER, SIERRA BLANCA MEDICAL ASSOCIATES, P.A., VICKIE WILLIAMS, D.O., and GARY JACKSON, D.O.,

Defendants.

MEMORANDUM OPINION AND ORDER

The subjects of this Memorandum Opinion and Order are: (1) defendants' Motion for Partial Summary Judgment Based on Immunity under Federal and State Law, filed August 15, 1994; (2) defendants' Motion for Summary Judgment on the Merits of Plaintiffs' Federal Antitrust and State Law Claims, filed August 15, 1994; and (3) plaintiffs' Motion in Limine to Preclude Defendants from Introducing "Competence" Evidence, filed November 7, 1994. After a careful review of the pleadings and attached documentation, the law and facts, I conclude that each of these three motions should be denied.

I. Procedural facts:

Plaintiffs, Dr. Arlene Brown, a family practitioner[1] in Ruidoso, New Mexico and her corporation, Family Practice Associates, P.C. ("FPA"), sued defendants (a hospital/health-care service corporation, the hospital administrator, and two staff physicians and their medical corporation) alleging violations of Section 1 and Section 2 of the Sherman Act, 15 U.S.C. §§ 1 and 2, the New Mexico Antitrust Act, and the New Mexico Unfair Trade Practices Act, and asserting claims under the common law of New Mexico (breach of contract, intentional interference with contractual and prospective contractual business relations, defamation and prima facie tort). Plaintiffs contend that defendants illegally excluded Dr. Brown and her corporation from the market for obstetric services in Ruidoso, New Mexico by revoking Dr. Brown's obstetrical privileges at Lincoln County Medical Health Center ("LCMC") on pretextual grounds. Plaintiffs seek both injunctive relief and damages.

Defendants have moved for partial summary judgment based on immunity with respect to plaintiffs' federal antitrust claims for damages, plaintiffs' state law claims for damages and any claims that arise out of the termination of Dr. Brown's obstetrical privileges[2] or the

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[1] Defendants stipulate that Dr. Brown is a competent family practitioner, able to handle certain types of obstetrical patients on her own without seeking consultation. Transcript of Motion Hearing held November 22, 1994 at p. 11.

[2] LCMC revoked Dr. Brown's obstetrical privileges but as of the date of this opinion, Dr. Brown still has general hospital privileges at LCMC.

reporting of the termination of Dr. Brown's obstetrical privileges to the National Practitioner Data Bank. Defendants also seek summary judgment on the merits of all of plaintiffs' federal and state law claims.

II. Background facts:

In 1983, Dr. Brown set up her family medical practice[3] in Ruidoso assisted by a recruitment contract with defendant Presbyterian Healthcare Services ("PHS"). At that time, Dr. Brown was a member of the staff of LCMC where she had hospital privileges. LCMC is managed and operated by PHS. PHS did not recoup its monetary advances to Dr. Brown under the contract as was expected.[4] In 1992, Dr. Brown's contractual obligation to PHS was discharged in bankruptcy, resulting in a loss on the contract to PHS of approximately $486,000.

Although the facts are disputed, plaintiffs support their claims with the following deposition and affidavit testimony. In November or December 1990, Dr. Brown began experiencing difficulties in obtaining obstetrics consultations with defendant Dr. Vickie Williams, who is a specialist in obstetrics and gynecology and also is a

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[3] When Dr. Brown began her practice, it was a solo practice known as Arlene Brown, MD, Family Medicine. In January 1990, Dr. Brown incorporated her practice which was then known as Family Practice Associates.

[4] Dr. Brown, like other physicians under contract with PHS, was expected to begin repaying the PHS contract advances as soon as her practice became established; on average, PHS would break even on its physician recruitment contracts after two and one half years.

member of the LCMC staff. From February 1991 until the arrival of Dr. Debra Hewitt[5] in September 1992, Dr. Williams was the only obstetrical specialist in Ruidoso with whom Dr. Brown could consult. Dr. Williams had started her practice in Ruidoso in July 1990, with her husband and co-defendant, Dr. Gary Jackson, who also is a member of the medical staff of LCMC. Drs. Williams and Jackson were shareholders of defendant Sierra Blanca Medical Associates ("Sierra Blanca") and allegedly were in economic competition with Dr. Brown.

By late 1991 or early 1992, a personality conflict had developed between Dr. Brown and Dr. Williams. During this time in a telephone conversation, Dr. Williams accused Dr. Brown of stealing patients from her in a loud and profane voice that could be heard by Dr. Brown's nearby office staff. Dr. Brown testified that Dr. Williams screamed obscenities at Dr. Brown during several other loud outbursts. In January 1992, Dr. Brown met with defendant Valerie Miller, LCMC Administrator, and discussed the problems Dr. Brown was encountering with Dr. Williams. Ms. Miller agreed that if any of Dr. Brown's patient files were tagged for review,[6] that review would be conducted by someone not on the LCMC medical staff

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[5] When Dr. Hewitt moved to Ruidoso she shared office space with Dr. Williams and allegedly divided obstetrics patients with Dr. Williams until Dr. Williams dropped out of the obstetrics market in November 1993.

[6] LCMC screens all obstetrics patient records or charts as part of its standard, ongoing quality assurance procedure. LCMC subjects those charts that fail to comply with screening criteria or those charts about which medical personnel express concern to further review.

to avoid any improper appearance that might result if Dr. Williams reviewed Dr. Brown's charts.

A LCMC staff member testified that Dr. Jackson, who is Dr. Williams' spouse, berated Dr. Brown over the phone, while he was standing in front of a group of LCMC personnel at the nurses station, by telling Dr. Brown that she had not followed accepted standards of care. A nurse who was present testified that after Dr. Jackson hung up the telephone he said to everyone present: "If you're not going to act in a responsible manner, then your license to kill and steal should be taken away. She doesn't ask for consult when she should because she doesn't want to share the money."

On several occasions Teresa McCallum, the OB unit managing nurse, expressed anti-Semitic remarks about Dr. Brown. Nurse McCallum has admitted in her testimony that on two separate occasions in 1991 or 1992, in her office at work, she referred to Dr. Brown as "JB" which Nurse McCallum explained is a term that means "Jewish Bitch." Nurse McCallum also testified that she called Dr. Brown a "JB" in front of Dr. Williams on at least one of the occasions and that she did not recall who else was present. LCMC did not discipline Nurse McCallum until some point after this suit had been pending. LCMC contends that is knew nothing about Nurse McCallum's anti-Semitic remarks until McCallum was deposed in this lawsuit. However, Dr. Brown testified that she reported Nurse McCallum's remarks to Ms. Miller in 1991 or 1992.

Although Nurse McCallum denied having made any other derogatory statements about Dr. Brown, a witness testified that at a social gathering Nurse McCallum stated

to Dr. Jackson, in front of some LCMC staff members, "We've got the Jew Bitch."[7] Nurse McCallum was referring to ongoing proceedings against Dr. Brown that lead to the revocation of her obstetrics privileges at LCMC. On another occasion while at work and in the presence of other staff members, Nurse McCallum was heard to say in reference to Dr. Brown that "Hitler had some good ideas, but he didn't get everybody that he should."

In addition, a LCMC staff member testified that Dr. Roger Beechie, Chief of Staff of the LCMC Medical staff and Vice-Chair of the Board of Trustees of LCMC during much of the period at issue, told a LCMC staff member that Dr. Brown was stupid, that he hated to deal with her and that she was malpractice waiting to happen. The staff member also stated that Dr. Beechie volunteered to her that Brown is Jewish, that she was tight with a dollar, was afraid she might miss a few bucks, and did not call for help when she needed it because she might have to share.

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[7] LCMC terminated Teresa McCallum sometime during the Fall of 1994, and Ms. McCallum is currently appealing her termination. Dr. Brown stated that after she was elected Physician of the Year by the New Mexico Chapter of the American Academy of Family Practice Physicians in 1994, Academy officials contacted Dr. Brown to inform her that they had received three anonymous letters criticizing her election. One of the letters was mailed to the Academy in a hand-addressed envelope. After plaintiffs' handwriting expert analyzed exemplars along with the hand-addressed envelope, the expert concluded that the writing on the envelope matched Ms. McCallum's handwriting. Supplemental Affidavit of Arlene Brown at p. 2. Defendants have also conceded that Ms. McCallum wrote anonymous letters to the Academy criticizing Dr. Brown's election.

Prior to Dr. Brown's discharge in bankruptcy, Dr. Beechie stated in a meeting that he could bankrupt any physician in Ruidoso and could see to it that Dr. Brown's note was called in for payment. The 1992 discharge in bankruptcy had angered members of the Board of Trustees of LCMC even though PHS, not LCMC, was responsible for the debt.

PHS representatives actively tried to dissuade physicians from practicing with Dr. Brown and FPA. When Dr. Stephen Frey decided to join Dr. Brown's practice in May 1992, LCMC Board Chairman W.C. "Dub" Williams refused to consider having the hospital provide a recruitment contract to Dr. Frey because offering a recruitment contract to a doctor in Dr. Brown's practice would be "putting good money after bad." In addition, Bill Norris, a full time recruiter for PHS and Director of Regional Services, called Dr. Frey before he joined Dr. Brown's practice, informed him of Dr. Brown's financial history, and discussed the fact that there were a couple of political factions in Ruidoso which would result in no referrals from Dr. Beechie if Dr. Frey were to join Dr. Brown's practice.[8]

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[8] Dr. Brown also testified that while Dr. Frey was an associate with FPA, Dr. Frey had applied for C-section privileges with LCMC but was denied those privileges because of malpractice insurance coverage issues. Dr. Brown was chief of staff at the time and was involved in Dr. Frey's application. On October 24, 1994, after Dr. Frey had left FPA and had begun his employment with LCMC, the OB Committee granted Dr. Frey C-section privileges and stated that the previous denial was not due to insurance issues but rather, because there had not been enough C-sections for two OB's to perform. Supplemental Affidavit of Arlene Brown at pp. 3-4.

Dr. Mark Rieb testified that PHS also interfered with Dr. Brown's efforts to recruit him in 1992. Dr. Rieb contacted LCMC and PHS about the possibilities of a financial package. When Dr. Rieb explained to the PHS recruiter that he was interested in working with Dr. Brown, the recruiter told him that PHS would not have anything to do with Dr. Rieb unless he decided not to go with Dr. Brown. Dr. Rieb stated that he received an impression from the recruiter that Dr. Brown was not doing well and that if he were to join her, he also would not do well.

In January 1992, after Ms. Miller had agreed that any review of Dr. Brown's medical records should be conducted by physicians outside of LCMC, medical records of three of Dr. Brown's obstetrics patients at LCMC were brought to the attention of LCMC's OB/Family Practice Committee ("OB Committee") for review. Although these three records were placed on the OB Committee's agenda for consideration, there were no written complaints about the records, contrary to Article 6.1.1 of the LCMC bylaws. Dr. Williams, who was chair of the OB Committee, identified one of Dr. Brown's medical records for review. Nurse McCallum identified the other two records for review allegedly because other nurses had reported their concerns about these two patients to Nurse McCallum.

Ms. Miller asked Drs. James Hutchison and Gary Aisenbrey, two Albuquerque specialists, to review the three files in the spring of 1992. Dr. Hutchison is an employee of PHS. Defendants state that Dr. Aisenbrey is not an employee of PHS although his group has a contract with PHS. However, Dr. Hutchison testified that Dr. Aisenbrey is on the medical staff of PHS as a member of

the department of obstetrics and gynecology and that he has privileges as a perinatologist with PHS.

The OB Committee's comments accompanied the three files that Dr. Hutchison reviewed, which indicates that the files first had been reviewed by LCMC staff, contrary to Ms. Miller's agreement with Dr. Brown. Both of the specialists criticized the care Dr. Brown provided in two of the cases; one specialist questioned her care in the third case.[9] Dr. Hutchison submitted a letter to LCMC stating that the physician's competence to handle high risk obstetrical cases was subject to question and that in the interest of quality health care and patient safety he would consider requesting that the physician obtain obstetrical consultation for any high risk obstetrics patient. On July 13, 1992, the LCMC Medical Executive/ Patient Care Committee ("Medical Executive Committee")[10] met to consider the specialists' conclusions. At the time, Dr. Brown was LCMC's chief of staff and chair of the Medical Executive Committee. At the meeting, Dr. Brown distributed a written response to the reviewers'

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[9] Dr. Aisenbrey testified that Dr. Hutchison asked for his comments in order to provide "constructive criticism" and that the information provided to Dr. Aisenbrey was not a sufficient basis for a decision to restrict privileges. Deposition of Gary Aisenbrey, at pp. 5, 16.

[10] The Medical Executive Committee is the governing committee of the medical staff. It oversees the medical staff's responsibility to provide quality patient care and recommends actions affecting the clinical privileges of medical staff members to the LCMC Board of Trustees. The Board of Trustees is responsible for determining whether and to what extent a physician should be granted or should retain clinical privileges at LCMC.

comments and discussed the cases. Dr. Brown acquiesced in the Committee's recommendation that she obtain consultations on all high-risk obstetric patients when possible. Dr. Brown stated that she felt she already had been obtaining consultations and that she had no problem in continuing that practice. However, she also expressed a concern about not always having been able to obtain a timely consultation with Dr. Williams when Dr. Brown had sought one in the past.

In November 1992, Nurse McCallum and Dr. Williams brought forward another chart of Dr. Brown's for review. Defendants assert that this file was selected for review under the hospital's standard quality assurance screening criteria. In November 1992, Dr. Brown had treated in her office a patient who might have been considered to be in pre-term labor, a high risk condition. Dr. Brown did not seek an obstetrical consultation before prescribing terbutaline for this patient. Dr. Brown argues that under the standards set forth in the Accreditation Manual for Hospitals, she was not exercising her *hospital* privileges when she treated this patient in her office.

The OB Committee discussed this chart during its November 23, 1992 meeting and recommended that Dr. Brown obtain a consultation with a specialist in high risk cases. Apparently, the OB Committee overlooked the consultation restriction that had already been imposed on Dr. Brown's privileges. After the November 23, 1992 meeting, Ms. Miller wrote to Dr. Brown informing her that the matter would be raised again before the OB Committee in January 1993 and that the consultation requirement was mandatory even though the original requirement was that Dr. Brown obtain consultations when possible.

In early 1993, Dr. Williams brought one more of Dr. Brown's medical charts before the OB Committee for review. Defendants again assert that the record was selected for review under standard screening criteria. On January 4, 1993, an obstetrical patient of Dr. Brown's, who would have been classified as high risk, was admitted to LCMC at approximately 3:40 a.m. in pre-term labor. Dr. Brown was notified at 4:00 a.m. On two previous occasions, the patient had been hospitalized in preterm labor, and on each of those occasions, Dr. Brown had obtained a consultation from either Dr. Williams or Dr. Hewitt. On January 4, 1993, without consultation, Dr. Brown initiated the same medication that the consultants had recommended on the two previous occasions. When Dr. Brown discovered later during the morning of January 4, 1993 that the medication was not effective, she called for and received consultation.

Because of her previous problems with Dr. Williams, in January 1993, Dr. Brown invited Dr. Williams to lunch in an effort to achieve a reconciliation. During the course of that meeting, Dr. Williams told Dr. Brown that Dr. Williams' business, Sierra Blanca, needed to double its obstetrics patient volume in order to remain viable. Dr. Brown also testified that since Dr. Hewitt had opened her obstetrics practice in September 1992, Drs. Williams and Hewitt were dividing the patients that previously had been seen exclusively by Dr. Williams.

In addition, Dr. Brown presents evidence that Drs. Williams and Hewitt each charged $1,610.00 for OB services and delivery, whereas Dr. Brown was charging $1,110 for the same services during the same period. Plaintiff's economics expert, Brian McDonald, PhD, noted

that as of May 1993, before Dr. Williams dropped out of the obstetrics market in November 1993, she and Dr. Hewitt each had 30% of the market. Dr. Brown's business, FPA, had 30% of the market in early 1993 before revocation of Dr. Brown's privileges. By 1994, Dr. Hewitt's share of the market had increased to 85%.

The OB Committee examined the last two of Dr. Brown's charts that were brought before it for review and recommended that the Medical Executive Committee undertake a formal peer review of Dr. Brown's actions. On April 12, 1993, an ad hoc hearing panel consisting of LCMC Drs. Wolfel, Wardlaw, and Gorman convened and subsequently issued a report in which it concluded that Dr. Brown's privileges to practice obstetrics at LCMC should be removed. Ms. Miller, Dr. Williams and Dr. Brown testified at the hearing. Dr. Brown alleges that Dr. Williams was the primary witness to testify on the merits against her. During the ad hoc hearing, Mr. W. Robert Lasater, LCMC's attorney, admitted that the hospital did not feel that there was an issue of whether Dr. Brown's actual care was appropriate in a given case but instead stated that the issue was whether or not Dr. Brown had broken the agreement to obtain consultation. In a subsequent letter, Mr. Lasater stated that Dr. Brown's competence was not at issue in her privileges revocation proceedings. Dr. Williams also testified at the ad hoc hearing that she had no "heartburn" with Dr. Brown's medical management.

The Medical Executive Committee, which consisted of Drs. Wolfel, Wardlaw and Jackson, reviewed and adopted these findings. Dr. Jackson abstained from voting because he was an economic competitor of Dr.

Brown's, with the result that Drs. Wolfel and Wardlaw reviewed their own findings. However, Dr. Jackson was present during the committee's discussions. The Medical Executive Committee forwarded its findings to the LCMC Board of Trustees who on April 22, 1993 voted to terminate Dr. Brown's obstetrical privileges. Five board members voted to revoke Dr. Brown's obstetrical privileges. Five other members, including Valerie Miller, Roger Beechie (Chief of Staff at the time) and Gary Jackson, abstained. The members who abstained were present throughout the meeting, and Dr. Brown has presented testimony that Dr. Beechie and Dr. Jackson participated in the discussion.

Dr. Brown appealed the Board's decision, but the appellate panel, which consisted of three of the Board members who had voted to revoke Dr. Brown's obstetrical privileges in the first place, voted to uphold her revocation. However, the appellate panel recommended that after further training, Dr. Brown have the opportunity to reapply for obstetrical privileges. Upon review of the appellate panel's recommendation, the same five LCMC Board members who had voted for termination voted in favor of this modification and the five members who had abstained on the first vote also abstained as to the proposed modification.

Gary Mitchell, one of the LCMC Board members and chair of the appellate panel, stated that "this wasn't a medical issue . . . ". Instead, Mr. Mitchell represented that the revocation of Dr. Brown's obstetrical privileges was due to her failure to obtain consultations. Two other members of the appellate panel, Dub Williams and John Hightower, agreed with Mr. Mitchell's characterization of

the issue and testified that they did not remember saying that Dr. Brown had been negligent.

The peer review proceedings were not lengthy. The ad hoc hearing panel apparently met once for approximately five hours when it reviewed Dr. Brown's two charts, and on the next day it issued its recommendation that Dr. Brown's obstetrical privileges be revoked. The Medical Executive Committee met approximately one week later and adopted that recommendation. It appears that the Board of Trustees approved the Medical Executive Committee's recommendation in a matter of minutes. The appellate panel met for about one hour and forty-five minutes in its review of the termination of Dr. Brown's obstetrical privileges.

On April 23, 1993, LCMC notified the National Practitioner Data Bank that Dr. Brown's obstetrical privileges had been revoked. LCMC reported the action under a reporting code designated "incompetence/malpractice/negligence." Ms. Miller, on behalf of LCMC, reviewed and approved the use of the reporting code.

Dr. Lindley, plaintiffs' medical expert has reviewed the cases relied upon by LCMC to revoke Dr. Brown's obstetrical privileges. Dr. Lindley testified that even if Dr. Brown's decisions not to obtain consultation in the two cases could be interpreted as being violative of her consultation requirement, that would not justify the decision to revoke her obstetrical privileges or justify the conclusion that Dr. Brown posed a threat to patient safety. In addition, Dr. Leland Fellows, a board certified obstetrician at Gerald Champion Memorial Hospital in Alamogordo, New Mexico granted Dr. Brown obstetrical

privileges at his hospital and stated, after reviewing Dr. Brown's file at LCMC, that he could not discover any reason to believe Dr. Brown would pose a threat to the safety of obstetrics patients. A second nearby hospital has also granted Dr. Brown obstetrical privileges after reviewing Dr. Brown's file and LCMC's decision to revoke her obstetrical privileges.

III. Legal Standard for Summary Judgment:

Summary judgment is an integral part of the Federal Rules of Civil Procedure, which are intended to " 'secure the just, speedy and inexpensive determination of every action.' " *Celotex Corp. v. Catrett*, 477 U.S. 317, 327 (1986) (quoting Fed. R. Civ. P. 1). A motion for summary judgment may be granted only when "there is no genuine issue as to any material fact and . . . the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c). Summary judgment is proper when the pleadings, depositions, answers to interrogatories and admissions on file, as well as any affidavits, "show that there is no genuine issue as to any material fact . . . " Fed.R.Civ.P. 56(c). "Where the record taken as a whole could not lead a rational trier of fact to find for the non-moving party, there is no 'genuine issue for trial.' " *Matsushita Electric Industrial Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986). Although the material submitted by the parties in support of and in opposition to the motion must be construed liberally in favor of the party opposing the motion, *Harsha v. United States*, 590 F.2d 884, 887 (10th Cir. 1979), the burden on the moving party may be discharged by demonstrating the absence of evidence to support the nonmoving party's case. *Celotex, supra* at 324. In such a

situation, the moving party is entitled to judgment as a matter of law, "because the nonmoving party has failed to make a sufficient showing on an essential element of her case with respect to which she has the burden of proof." *Id.* at 322. Summary judgment is warranted even when state of mind is at issue, if the party opposing the motion fails to make the requisite showing to defeat the motion for summary judgment. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 256 (1986).

The Supreme Court in *Matsushita* stated that "summary judgment remains a vital procedural tool to avoid wasteful trials and may be particularly important in antitrust litigation to prevent lengthy and drawn-out litigation that has a chilling effect on competitive market forces." 475 U.S. at 585-88, 593-94. However, the Tenth Circuit Court of Appeals has recognized the prevailing sentiment that summary judgment is disfavored in antitrust cases and that it should be used sparingly. *City of Chanute, Kansas v. Williams Natural Gas Co.*, 955 F.2d 641, 646-47 (10th Cir. 1992) (*citing Poller v. Columbia Broadcasting Sys., Inc.*, 368 U.S. 464 (1962)), *cert. denied*, 113 S.Ct. 96 (1992). "Summary procedures should be used sparingly in complex antitrust litigation where motive and intent play leading roles, the proof is largely in the hands of the alleged conspirators, and hostile witnesses thicken the plot." *Poller*, 368 U.S. at 473.

IV. Defendants' Motion for Partial Summary Judgment Based on Immunity under Federal and State Law:

Defendants moved for partial summary judgment based on the federal Health Care Quality Improvement

Act ("HCQIA"), 42 U.S.C. §§ 11101 to 11152, and on its New Mexico counterpart, the New Mexico Review Organization Immunity Act ("ROIA"), N.M.S.A. 1978 §§ 41-9-1 to -7 (Repl. Pamp. 1989)[11]. Doctors and hospitals who have acted in accordance with the requirements of the HCQIA are protected from damages sought by a disciplined doctor. Defendants seek immunity from damages for their acts that resulted in the revocation of Dr. Brown's obsterical privileges and for the reporting of Dr. Brown's loss of obstetrical privileges to the National Practitioner Data Bank.

Whether to grant immunity under the HCQIA is a question of law for the court to decide. *Bryan v. Holmes Regional Medical Center*, 33 F.3d 1318, 1332 (11th Cir. 1994). The HCQIA establishes immunity from liability only, and not immunity from suit. *Decker v. IHC Hospitals, Inc.*, 982 F.2d 433 (10th Cir. 1992), *cert. denied*, ___ U.S. ___, 113 S.Ct. 3041 (1993) (holding that motions to dismiss based on HCQIA immunity are not immediately appealable). *See also Manion v. Evans*, 986 F.2d 1036 (6th Cir.) (denial of motion to dismiss antitrust action against hospital's peer review committee on basis of HCQIA immunity is not appealable as the protection provided is against liability and not against suit), *cert. denied*, 114 S.Ct. 71 (1993).

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[11] Both the HCQIA and ROIA contain similar language and provide for limited immunity for professional review bodies engaged in peer review proceedings. While the HCQIA provides immunity from damages but not from claims for injunctive relief, the ROIA provides immunity to reviewing bodies for both damages and "other relief." N.M.S.A. 1978 § 41-9-4 (Repl. Pamp. 1989).

The HCQIA was enacted in response to the following congressional findings:

> (1) that there is a national need to restrict the ability of incompetent physicians to move from State to State; (2) that this problem can be remedied through effective professional peer review; and (3) that there is an overriding national need to provide incentive and protection from private money damages for physicians engaging in effective professional peer review.

42 U.S.C. § 11101. However, while Congress has stated that the purpose of the HCQIA is to protect innocent and often helpless consumers from abuses by bad doctors, the Act was not intended to insulate improper anticompetive behavior from redress. H.R. Rep. No. 903, 99th Cong., 2d Sess. 3 (1986), *reprinted in* 1986 U.S.C.C.A.N. 6384, 6386.

A. Application of HCQIA:

Immunity under the HCQIA may apply if the professional review action is taken by a professional review body, any person acting as a member or staff to the body, any person under a contract or other formal agreement with the body, and any person who participates with or assists the body with respect to the action. 42 U.S.C. § 11111(a)(1). The HCQIA defines "professional review action" as follows:

> An action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or

> welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician.

42 U.S.C. § 11151(9).

In this case, there is no question that the determination to revoke Dr. Brown's obstetrical privileges was taken by the Medical Executive Committee, a professional review body, nor is it disputed that the determination to revoke Dr. Brown's privileges falls within the definition of "professional review action."

B. Immunity under HCQIA:

To qualify for the immunity offered by the HCQIA, action taken by a peer review body must be made according to the following four standards:

> (1) in the reasonable belief that the action was in furtherance of quality health care,
>
> (2) after a reasonable effort to obtain the facts of the matter,
>
> (3) after adequate notice and hearing procedures . . . or after such other procedures as are fair . . . under the circumstances, and
>
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

42 U.S.C. § 11112(a).[12] Failure to meet any one of the four standards will defeat a defense of immunity under § 11112(a).

The HCQIA creates a presumption, rebuttable by a preponderance of the evidence, that a professional review action has met the above four standards. 42 U.S.C. § 11111(a). The Ninth Circuit has expressed the summary judgment standard in the following manner: "Might a reasonable jury, viewing the facts in the best light for the plaintiff, conclude that he has shown, by a preponderance of the evidence, that the defendants' actions are outside the scope of section 11112(a)?" *Austin v. McNamara*, 979 F.2d 728, 734 (9th Cir. 1992). The legislative history of the HCQIA indicates that its reasonableness requirements were intended to create an objective, rather than a subjective standard. "The test will be satisfied if the reviewers, with the information available to them at the time of the professional review action, would reasonably have concluded that their actions would restrict incompetent behavior or would protect patients." *Id.* (*citing* H.R. Rep. No. 903, 99th Cong. 2d Sess 10, *reprinted in* 1986 U.S.C.C.A.N. 6287, 6392-93).

Plaintiffs do not contend that defendants failed to provide them with adequate notice or procedures under

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[12] The ROIA sets forth the following similar standards: no person who is a member of a review organization shall be liable for damages or other relief (1) when that person acts in the reasonable belief that the action/recommendation is warranted (2) by facts known to the person after reasonable efforts to ascertain the facts, and (3) when done without malice toward the person affected. N.M.S.A. 1978 §§ 41-9-3, 41-9-4 (Repl. Pamp. 1989).

standard 3 of § 11112(a). Instead, plaintiffs assert that the peer review process did not meet standards 1, 2, and 4 of § 11112(a).

(1) Standard 1 of the HCQIA:

Standard 1 of § 11112(a) requires that a peer review action be taken "in the reasonable belief that the action was in the furtherance of quality health care." Plaintiffs contend that the revocation of Dr. Brown's obstetrical privileges was not predicated on the furtherance of quality health care. Plaintiffs have presented evidence that the peer reviewers decided to terminate Dr. Brown's obstetrical privileges because Dr. Brown had broken her agreement to obtain consultations. Plaintiffs have also submitted testimony in support of their argument that a reasonable reviewer would not have revoked Dr. Brown's obstetrical privileges on the basis of the two reviewed cases. Plaintiffs further argue that subsequent to LCMC's decision to revoke Dr. Brown's obstetrical privileges, two nearby hospitals have granted Dr. Brown obstetrical privileges and have concluded that Dr. Brown was not a threat to the safety of obstetrics patients.

In addition, plaintiffs assert that subjective intent, malice and bad faith are relevant to the inquiry under HCQIA even though plaintiffs appear to agree that Congress, in adopting the HCQIA, initially considered a subjective standard which it ultimately rejected in favor of a higher objective standard. Transcript of Motion Hearing held November 22, 1994 at pp. 44-46. The objective test under the HCQIA has been analogized to the objective test employed by courts in the context of civil rights

qualified immunity. *Fobbs v. Holy Cross Health System Corp.*, 789 F. Supp. 1054, 1063 (E.D. Cal. 1992), *aff'd in pertinent part*, 29 F.3d 1439 (9th Cir. 1994). With regard to qualified immunity, the Tenth Circuit Court of Appeals has stated that a "prima facie showing that a defendant may have proper reasons for the challenged conduct does not alone invoke qualified immunity at the summary judgment stage. The focus remains on whether the plaintiff has produced facts properly evidencing improper intent. To survive a summary judgment motion, a plaintiff must point to specific evidence showing the official's actions were improperly motivated." *Walter v. Morton*, 33 F.3d 1240, 1243 (10th Cir. 1994). *See also Lewis v. City of Ft. Collins*, 903 F.2d 752, 755 (10th Cir. 1990) ("in some cases, the determination of the 'objective' reasonableness of a [defendant's] conduct rests on establishing whether the defendant acted with an impermissible motive or intent – a highly 'subjective' factual element").

I agree that the test under HCQIA requires an inquiry of objective reasonableness on the part of the medical peer review group. However, I conclude that under the facts of this case evidence of bad faith may be material to the inquiry of whether the peer review group's action was objectively reasonable. Plaintiffs have produced evidence that LCMC's motivation in its initial selection of Dr. Brown's files for review may not have reflected an interest in promoting quality health care. Both of the persons who tagged Dr. Brown's five files for review either expressed dislike of Dr. Brown or made anti-Semitic remarks about Dr. Brown. In addition, Dr. Williams was an economic competitor of Dr. Brown's.

Defendants assert that a reasonable medical reviewer legitimately and reasonably could have determined that revocation of Dr. Brown's obstetrical privileges was appropriate based on the record of the peer review proceeding which demonstrated that Dr. Brown either refused to obtain consultation for two high risk patients or that Dr. Brown was not able to recognize when she needed to obtain a consultation. Defendants argue that the record provided ample basis to support an objectively reasonable belief that the restriction of Dr. Brown's obstetrical privileges would further quality health care. Part of that basis rests upon Dr. Brown's own admission that she should obtain consultation in high risk cases. Brown Dep. at 461-69.

While it is a close call, after examining the evidence in the light most favorable to plaintiffs, I conclude that plaintiffs have submitted sufficient evidence, which if believed by a jury, would show by a preponderance of the evidence that defendants acted outside the scope of § 11112. Therefore, plaintiffs have raised a genuine issue of material fact with regard to whether defendants reasonably could have believed that their actions would restrict incompetent behavior or protect patients under standard 1 of § 11112(a).

(2) Standards 2 and 4 of the HCQIA:

In addition, I conclude that plaintiffs have presented sufficient evidence, which if believed by a jury, would show by a preponderance of the evidence that defendants did not make "a reasonable effort to obtain the facts in the matter" under standard 2 of § 11112(a). Defendants

cite numerous cases in support of their argument that they acted with objective reasonableness and made a reasonable effort to obtain the facts of this matter. *See Monroe v. AMI Hospitals of Texas, Inc.*, 1994 LEXIS 17755 (S.D. Tex, October 27, 1994); *Willman v. Heartland Hospital East*, 34 F.3d 605 (8th Cir. 1994); *Imperial v. Suburban Hospital Board of Trustees*, 37 F.3d 1026 (4th Cir. 1994); *Bryan*, 33 F.3d 1318.

However, in *Monroe*, the peer review process started in 1989 and lasted approximately two to three years. Several committees examined numerous files of the plaintiff-physician. *Id.* at *1. In 1989, the Executive Committee voted to conduct a three-month review of all admissions and consultations by plaintiff. *Id.* at *13. The Committee then engaged an outside independent consultant to review the cases that were flagged during the three-month review. *Id.* Cases that had been flagged during previous reviews were also sent to the outside reviewer. *Id.* After the outside reviewer examined seven cases, his comments were sent to the Internal Medicine Section Chiefs who reviewed the comments and drew conclusions. The seven cases were then referred to the Internal Medicine Department with a request for corrective action. *Id.* at *14.

In *Willman*, the hospital's peer review committee also engaged in an extensive review of plaintiff's charts. It examined 53 of plaintiff's cases before making its disciplinary recommendation. A total of approximately 65 physicians participated in plaintiff's review process. Although the Medical Executive Committee in *Willman* determined that four of plaintiff's case files did not reflect reasonable clinical judgment, the Committee voted

to defer any action pending review of another 41 of plaintiff's files in the subsequent year. Even after determining that 13 of the 41 files contained deficiencies, the Committee proposed only to reprimand plaintiff. Furthermore, defendant hospital requested that four outside physicians, who were not affiliated with hospital defendants, review a total of 51 of plaintiff's charts before making any disciplinary recommendation. Plaintiff's privileges were not revoked until he refused to discuss the hospital's proposal.

Similarly, in *Imperial,* the hospital engaged in a lengthy and complete process before concluding that plaintiff-physician should not be reappointed. The hospital listed eight different reasons, most of which referenced particular medical records, in support of its decision. The hospital held a hearing that lasted ten hours extending over three days, and the panel was unanimous in its conclusion. The Court of Appeals could not find anything in the record suggesting a reason for the hospital's action other than a legitimate health care quality concern.

In *Bryan,* the court reversed the jury's verdict for plaintiff-physician and concluded that the hospital should have been entitled to immunity under the HCQIA. However, in *Bryan,* plaintiff had been the subject of more than 50 written incident reports involving unprofessional, disruptive or abusive behavior. Despite the many written reports of plaintiff's abusive conduct, defendant hospital took no action for three years. In 1988, the Ad Hoc Committee recommended graduated suspension for any future problems. One month later, plaintiff had another outburst and received a one-week suspension. A four-

week suspension followed additional misbehavior. Plaintiff's problems persisted and in 1990, the hospital finally indefinitely suspended plaintiff's clinical privileges. Plaintiff's peer review hearing panel consisted of seven physicians who met in four sessions.

See also Rooney v. Medical Center Hospital of Chillicother, Ohio, 1994 LEXIS 7420 (S.D. Ohio 1994) (hospital's investigation into plaintiff's conduct continued for at least ten years, and its Medical Executive Committee considered physician's conduct at least 18 times during this ten year period); *Austin,* 979 F.2d 728 (hospital identified deficiencies in 26 of plaintiff-physician's cases from 1985 and three problematic cases from 1986; the audit committee voted to have an outside reviewer further evaluate plaintiff's charts and suggested the hospital continue to monitor his work; the ad hoc committee met four times in its investigation of plaintiff's conduct); *Oksanen v. Page Memorial Hosp.,* 945 F.2d 696 (4th Cir. 1991) (complaints against physician spanned a four-year period, after which physician's hospital privileges were suspended for a one-year probationary period), *cert. denied,* 112 S.Ct. 973 (1992); *Fobbs,* 789 F. Supp. 1054 (although committee initially considered only four of plaintiff's cases involving intra-abdominal laser surgeries, plaintiff had only just begun to perform intra-abdominal laser surgeries; committee later conducted a random review of plaintiff's cases and found four more of plaintiff's cases were improperly managed); *Smith v. Ricks,* 798 F. Supp. 605 (N.D. Cal. 1992) (hospital reviewed five patient files and a sixth file of a patient who died under plaintiff's care; review of plaintiff-physician commenced in early 1988, and final decision to revoke privileges was issued in

1990 after many months of investigations and hearings; appeal process alone included nine individually held sessions that resulted in over 1,500 pages of transcription), *aff'd* 31 F.3d 1478 (9th Cir. 1994); *Islami v. Covenant Medical Center, Inc.*, 822 F. Supp. 1361, 1365 (N.D. Iowa 1992) (before requiring plaintiff to obtain a mandatory consultation, hospital reviewed 95 of plaintiff's charts, some of which also were reviewed by external consultants).

In this case, defendants concede that only two of Dr. Brown's cases were the subjects of the peer review action that resulted in the conclusion that Dr. Brown had violated her consultation requirement and lead to the revocation of Dr. Brown's obstetrical privileges. Transcript of Motion Hearing held November 22, 1994 at pp. 32-33. In addition, defendants admit that the Medical Executive Committee examined only three other of Dr. Brown's files, which were the same files reviewed by the two Albuquerque specialists who both were affiliated with PHS. In addition, plaintiffs have presented evidence which has raised troubling questions regarding how Dr. Brown's files were selected for review, how the proceedings were conducted, the composition of the committees, and the substance of the files that LCMC used to revoke Dr. Brown's obstetrical privileges.

I conclude that defendants' motion for summary judgment based on immunity under the HCQIA also should be denied because of genuine issues of material fact relating to standard 2 of § 11112(a). It likewise follows plaintiffs have shown that a genuine issue of material fact exists as to standard 4 of § 11112(a) regarding whether defendants acted "in the reasonable belief that

the action was warranted by the facts known after such reasonable effort to obtain facts . . . "

(3) Immunity for reporting restriction of privileges to national data bank:

Defendants also argue that they should be granted immunity under the HCQIA for their acts in reporting to the National Practitioner Data Bank that Dr. Brown's obstetrical privileges had been revoked. The HCQIA provides limited immunity to anyone reporting peer review action information to the data bank provided that the person making the report is "without knowledge of the falsity of the information contained in the report." 42 U.S.C. § 11137(c). While it is true that LCMC revoked Dr. Brown's obstetrical privileges, Ms. Miller approved the use of the code "incompetence/malpractice/negligence" as an explanation for the revocation. She testified that she believed that code was appropriate since Dr. Brown's conduct could fairly be described as "negligent or below acceptable standards of competence." Miller Dep. at p. 13.

However, at that time, Ms. Miller was aware of Mr. Lasater's letter dated April 22, 1993, in which he stated that "the issue was not whether, on these occasions, Dr. Brown met the minimum standards required of a family practitioner taking care of a high risk patient. The issue, I believe was whether Dr. Brown had failed to comply with her agreement to obtain consultation for high risk patients." (Dep. Exh. #14). Ms. Miller was also present during discussions at the ad hoc panel hearing and the Board of Trustees vote on the revocation of obstetrical

privileges, at which no one described Dr. Brown's conduct as incompetence or malpractice or negligence.

I conclude that plaintiffs have presented sufficient evidence, which if believed by a jury, would show by a preponderance of the evidence that Ms. Miller did have knowledge of the falsity of the descriptor code she selected and submitted for the data bank report. Hence, defendants' motion for summary judgment based on immunity under the HCQIA for actions in reporting Dr. Brown's revocation of obstetrical privileges to the data bank should be denied.

V. Defendants' Motion for Summary Judgment on the Merits of Plaintiffs' Claims under Section 1 of the Sherman Act:

Section 1 of the Sherman Act provides that "[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several states . . . is declared illegal. 15 U.S.C. § 1. The Supreme Court has long recognized that section 1 was intended to prohibit only unreasonable restraints on competition. *Business Electronics Corp. v. Sharp Electronics Corp.*, 485 U.S. 717, 723 (1988). "The Sherman Act was enacted to assure competition in the marketplace by 'protecting the economic freedom of participants in the relevant market,' and is thus said to protect only against injury sustained as a result of anticompetitive activities." *Bhan v. NME Hospitals, Inc.*, 669 F. Supp. 998, 1012 (E.D. Cal. 1987) (citations omitted), *aff'd*, 929 F.2d 1404 (9th Cir. 1991).

Generally, a plaintiff must prove an antitrust injury by showing evidence of the following elements: (1) an agreement or conspiracy among two or more persons or distinct business entities; (2) by which the persons or entities intend to harm or restrain competition; and (3) which actually injures competition. *Oltz v. St. Peter's Community Hosp.*, 861 F.2d 1440, 1445 (9th Cir. 1988).

Defendants attack only element 1, the existence of a conspiracy. In support of their motion, defendants' argument is twofold: (1) defendants do not have the legal capacity to conspire, and (2) plaintiffs have not produced sufficient evidence that an unlawful conspiracy actually existed.

A. Legal capacity to conspire:

Plaintiffs must establish proof of a concerted action involving two or more entities that are legally capable of conspiring. *See Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752 (1984). Plaintiffs allege that "Dr. Williams and Sierra Blanca . . . conspired with each other and with LCMC, Ms. Miller and [PHS]" to exclude plaintiffs from the obstetrical services market in the Ruidoso area. Complaint, at ¶ 62. Defendants contend that a conspiracy is impossible in this case because in the medical peer review context, a hospital and its medical staff members comprise a single entity and therefore are incapable of conspiring with each other as a matter of law. *See Oksanen v. Page Memorial Hosp.*, 945 F.2d 696, 699 (4th Cir. 1991) (en banc), *cert. denied*, 112 S.Ct. 973 (1992); *Nurse Midwifery Associates v. B.K. Hibbett, M.D.*, 918 F.2d 605, 614 (6th

Cir. 1990) ("intracorporate conspiracy doctrine"[13] applies when members of the medical staff were acting as agents of the hospital), *modified in part*, 927 F.2d 904 (6th Cir.), *cert. denied*, 112 S.Ct. 406 (1991).

The Tenth Circuit Court of Appeals has not addressed this exact question, and there is a split among the other circuits that have considered the issue. Some circuit courts have held that a hospital is incapable of conspiring with its medical staff during the peer review process when the functional relationship between them is analogous to that of corporation and its agent or officer. *Oksanen*, 945 F.2d at 702-05; *see also Pudlo v. Adamski*, 2 F.3d 1153 (Table), 1993 WL 306105, 7th Cir. Aug. 9, 1993), *cert. denied*, 114 S.Ct. 879 (1994); *Nurse Midwifery*, 918 F.2d at 614; *Nanavati v. Burdette Tomlin Memorial Hosp.*, 857 F.2d 96, 118 (3d Cir. 1988), *cert. denied*, 489 U.S. 1078 (1989); *Weiss v. York Hosp.*, 745 F.2d 786, 817 (3d Cir. 1984), *cert. denied*, 470 U.S. 1060 (1985). Unilateral actions of a single enterprise are excluded from the purview of § 1 of the Sherman Act despite any corresponding restraint on trade. *Oksanen*, 945 F.2d at 703. The court in *Oksanen* concluded that the staff of a hospital acts as an agent of the hospital during the peer review process and as such operates as a single entity. *Id.*

The Ninth and Eleventh Circuit Courts have taken a contrary view. The Eleventh Circuit held that a hospital and the members of its medical staff are legally separate

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[13] Under the intracorporate conspiracy doctrine, a corporation cannot ordinarily conspire with its agents or employees because the corporation and staff are considered a single entity. *See Nurse Midwifery*, 918 F.2d at 612.

entities capable of conspiring with one another under the Sherman Act. *Todorov v. DCH Healthcare Auth.*, 921 F.2d 1438 (11th Cir. 1991); *Bolt v. Halifax Hosp. Medical Ctr.*, 891 F.2d 810, 819 (11th Cir. 1990); *Oltz v. St. Peter's Community Hosp.*, 861 F.2d 1440, 1450 (9th Cir. 1988). In *Bolt*, the court stated that "[e]ach member practices medicine in his individual capacity; each is a separate economic entity potentially in competition with other physicians." *Id; see also Nurse Midwifery*, 918 F.2d at 614 ("Members of a medical staff are not salaried employees of the hospital but are independent medical practitioners, some in direct competition with each other and with applicants for privileges."). The court in *Oltz*, while not considering the issue in the context of medical peer review proceedings, held that a hospital has the capacity to conspire with members of its medical staff. 861 F.2d at 1450.

Even though the Fourth and Sixth Circuit Courts have held that medical staff cannot conspire with the hospital, these circuit courts have also noted that intracorporate immunity protection should not apply to preclude a conspiracy when physicians are making staff privilege recommendations concerning a competitor. *See Oksanen*, 945 F.2d at 705-06; *Nurse Midwifery*, 918 F.2d at 614. "[W]hen competing physicians are making privilege recommendations concerning another competitor, sufficient anticompetitive concerns are raised to warrant a conclusion that the members of the medical staff are not acting as agents of the hospital for purposes of applying the intracorporate conspiracy doctrine to preclude a conspiracy among staff members." *Id.* 918 F.2d at 614. Medical staff can be comprised of physicians with independent and at times competing economic interests and therefore,

when these actors join together to take action among themselves, they are unlike a single entity and have the capacity to conspire as a matter of law. *Oksanen*, 945 F.2d at 705-06. *See also Capital Imaging Associates, P.C. v. Mohawk Valley Medical Associates, Inc.*, 996 F.2d 537, 544-45 (2d Cir. 1993) (adopting the reasoning in *Bolt* and *Oksanen* that when staff physicians have independent and competing economic interests, the doctors are not a single entity and have the ability to conspire).

In this case, plaintiffs urge that I follow the Ninth and Eleventh Circuits or that I apply the "personal stake" exception to the intracorporate conspiracy doctrine. Plaintiffs have alleged that Drs. Jackson, Williams, Hewitt, and Beechie[14] were direct competitors of Dr. Brown and have presented testimony with regard to the roles played by Drs. Jackson, Williams and Beechie in various committee meetings or hearings concerning the revocation of Dr. Brown's obstetrical privileges. Furthermore, plaintiffs have presented testimony with regard to Dr. Williams role in selecting Dr. Brown's files for review.

Additionally, plaintiffs allege that PHS had Physicians Agreements with Drs. Williams, Hewitt and Jackson, so that PHS would have had a stake in those doctors' economic well-being. Plaintiffs also allege that sometime in 1993, LCMC began to contemplate buying the practices of and employing local physicians, including family practitioners, which would result in LCMC's entry in the

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[14] Dr. Beechie allegedly competed with the plaintiffs as a family practitioner.

market itself as a competitive provider of OB and family practice services. LCMC has now entered that market.

Defendants contend that even if the Tenth Circuit were to recognize the "personal stake" exception, it is inapplicable where the corporate agent with an alleged independent stake in achieving the corporation's goal "cannot cause a restraint to be imposed.["] *Oksanen*, 945 F.2d at 705. In *Oksanen*, the court held the exception did not apply because the medical staff had insufficient control over the decisions of the hospital board. In examining whether medical staff can impose a restraint, the court in *Islami v. Covenant Medical Center, Inc.*, found that the key question is whether medical staff had the ability to coerce or unduly influence the decision. 822 F. Supp. 1361, 1383 (N.D. Iowa 1992) (citing *Weiss v. York Hosp.*, 745 F.2d 786, 819 n.57 (1984) and P. Areeda, *Antitrust Law* ¶ 1471(h)).

I do not need to determine whether the Tenth Circuit would hold that hospitals are capable of conspiring with staff because I recognize that an exception to the intracorporate immunity doctrine applies when the "agents" have a personal stake involved. The Tenth Circuit has indicated a willingness to recognize the "personal stake" exception to the intracorporate conspiracy doctrine in the franchisor-franchisee context. *Motive Parts Warehouse v. Facet Enterprises*, 774 F.2d 380, 387-88 (10th Cir. 1985). In addition, I find the reasoning of the courts in *Bolt*, *Oksanen*, and *Nurse Midwifery* persuasive. While hospital staff physicians may act as agents for the hospital in peer review proceedings, the physicians frequently have independent and competing economic interests, thereby making them capable of conspiracy. Even if I were to decide that the personal stake exception did not apply and that

doctors and hospitals were incapable of conspiring, courts have agreed that medical staff doctors are capable of conspiring with each other in peer review proceedings. *Willman*, 34 F.3d at 612; *Oksanen*, 945 F.2d at 706; *Weiss*, 745 F.2d at 815-16. I conclude that plaintiffs have provided sufficient evidence to raise genuine issues of material fact with regard to whether certain members of the LCMC staff who were involved in the peer review proceedings acted for their own personal benefit and whether they could have influenced the final decision to revoke Dr. Brown's obstetrical privileges.

B. Existence of conspiracy:

"To survive a motion for summary judgment . . . , a plaintiff seeking damages for a violation of a § 1 of the Sherman Act must present evidence 'that tends to exclude the possibility' that the alleged conspirators acted independently." *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 588 (1986) (*quoting Monsanto Co. v. Spray-Rite Serv. Co.*, 465 U.S. 752, 764 (1984)). In the context of antitrust litigation, the range of inferences that may be drawn from ambiguous evidence is limited; the non-moving party must set forth facts that tend to preclude an inference of permissible conduct or that casts doubt on an inference of independent action by defendants. *Capital Imaging*, 996 F.2d at 542, 545 (2d Cir. 1993) (*citing Matsushita*, 475 U.S. at 587-88). Although the non-moving party may rely on direct evidence of the existence of a conspiracy, more often the party will have to rely on circumstantial evidence. *Bolt v. Halifax Hosp. Medical Ctr.*,

891 F.2d 810, 819 (11th Cir.), *cert. denied*, 495 U.S. 924 (1990).

When relying on circumstantial evidence to prove the existence of a conspiracy, a plaintiff first must show that a defendant has a non-legitimate motive for entering into the conspiracy. *See Matsushita*, 475 U.S. at 596-97. In other words, a plaintiff must show that the conspiracy would inure to the defendant's economic benefit. *Bolt*, 891 F.2d at 819. Second, the plaintiff must present evidence that tends to exclude the possibility that alleged conspirators acted independently and in a manner consistent with rational business objectives. *Monsanto*, 465 U.S. at 764. The plaintiff need not prove an intent on the part of the conspirators to restrain trade. *Bolt*, 891 F.2d at 819-20.

"[I]f the evidence is as consistent with permissible independent business interests as with an illegal conspiracy, then the plaintiffs fail to create a fact issue on the existence of a section one conspiracy *unless* the ambiguity is negated by evidence tending to exclude the possibility that the defendants were pursuing independent interests." *Key Financial Planning Corp. v. ITT Life Ins. Corp.*, 828 F.2d 635, 639 (10th Cir. 1987). Quality of health concerns can provide a permissible independent basis for restricting a physician's medical staff privileges. *See Cooper v. Forsyth County Hosp. Auth.*, 789 F.2d 278, 282 (4th Cir.), *cert. denied*, 479 U.S. 972 (1986); *Anesthesia Advantage, Inc. v. Metz Group*, 759 F. Supp. 638, 650 (D. Colo. 1991); *Brown v. Our Lady of Lourdes Med. Ctr.*, 767 F. Supp. 618, 628 (D.N.J. 1991), *aff'd*, 961 F.2d 207 (3d Cir. 1992). "Because the purpose of peer review is to maintain quality patient care . . . , a peer review process that is at least as consistent with this lawful purpose as with an illegal

conspiracy to restrain trade cannot support an inference of antitrust conspiracy. . . . " *Willman*, 836 F. Supp. at 1531.

Defendants assert that any of plaintiffs' evidence of an actual conspiracy is at best equally compatible with defendants' averments of an independent action or reason for their decision. Specifically, defendants contend that their quality of care concerns provided a permissible independent basis for restricting Dr. Brown's obstetrical privileges and that plaintiffs have failed to point to evidence tending to exclude the possibility that the revocation of Dr. Brown's obstetrical privileges was an independent action based on legitimate concerns. Defendants argue that physician reviewers could reasonably conclude that Dr. Brown's skills in high risk obstetrics cases were inadequate, in that Dr. Brown was either unable to recognize when she needed a consultation or was unwilling to seek consultation; and therefore, defendants conclude that revocation of Dr. Brown's obstetrical privileges was warranted. In support of their arguments, defendants observe that even Dr. Brown and her medical expert could not brand such conclusions as unreasonable. *See* Brown Dep. at 461-69; Lindley Dep. at 45, 50-51, 56-57. Furthermore, each individual defendant, each member of the hearing panel and each voting member of the LCMC Board of Trustees has submitted an affidavit stating that he or she acted independently, while denying the existence of a conspiracy.

Defendants rely on several decisions in which courts have failed to find the existence of a conspiracy. *See Todorov v. DCH Healthcare Auth.*, 921 F.2d 1438 (11th Cir.

1991); *Willman v. Heartland Hosp. East*, 34 F.3d 605 (8th Cir. 1994).

In *Todorov*, the court decided that while plaintiff had submitted evidence suggesting that the hospital might have conspired with its physicians, the evidence did not exclude the possibility that the hospital acted unilaterally and procompetitively when it denied plaintiff hospital privileges. 921 F.2d at 1456. The court concluded that plaintiff had presented bare circumstantial evidence and that "to infer a conspiracy solely from the [physicians'] anticompetitive conduct and the board's denial of privileges would be, in effect, to criminalize perfectly legitimate conduct." *Id.* at 1458.

In *Willman*, the court found that the revocation of plaintiff's privileges was proper because defendants were motivated by legitimate concerns about the quality of patient care. 34 F.3d at 610. The court was unpersuaded by plaintiff's argument that the peer review proceedings were a sham and that termination of his privileges was intended to prevent him from competing. *Id.* The court reasoned that physicians who were not affiliated with defendant hospital and who did not practice in that locale had agreed that plaintiff had rendered substandard care. *Id.* at 611. Also, in *Willman*, the hospital had conducted an extensive review of plaintiff's patient files, and the court was convinced that there was no evidence of anticompetitive motive among plaintiff's peer reviewers. *Id.* at 611, 612.

See also Cooper, 789 F.2d at 281-82 (plaintiffs' evidence, consisting only of contacts and communications,

was insufficient to support an inference of anticompetitive conspiracy; moreover, defendants opposed granting of privileges due to quality of patient care concerns); *Anesthesia Advantage,* 759 F. Supp. at 651 (plaintiff's unsupported assertions that defendants' explanations concerning quality of care did not ring true and that defendant physicians acted in a manner contrary to their own economic interests failed to exclude the possibility that the alleged conduct was in furtherance of nonconspiratorial objectives).

In contrast, plaintiffs cite to several cases where the courts determined that a plaintiff had presented sufficient evidence of the existence of a conspiracy to merit a jury trial. *See Boczar v. Manatee Hospitals & Health Systems, Inc.,* 993 F.2d 1514 (11th Cir. 1993); *Bolt v. Halifax Hosp. Medical Ctr.,* 891 F.2d 810 (11th Cir. 1990); *Islami v. Covenant Medical Center, Inc.,* 822 F. Supp. 1361, 1385 (N.D. Iowa 1992); *Miller v. Indiana Hosp.,* 843 F.2d 139, 144 (3d Cir.), *cert. denied,* 488 U.S. 870 (1988).

In *Boczar,* the court concluded that a jury could have inferred the existence of a conspiracy between the hospital and members of its staff or peer review committees. The court considered the following facts: when plaintiff joined its staff, the hospital suffered defections by some of its ob/gyn staff and feared more losing more staff; more than half of the remaining ob/gyn specialists who were plaintiff's direct competitors openly opposed granting plaintiff privileges; plaintiff's practice was not typical of defendant hospital's ob/gyn physicians; and plaintiff's prices were significantly lower than those of competing physicians. Given these factors, the court reasoned that a jury could infer that the hospital began to think it would

be better to lose plaintiff than to risk additional dissatisfaction and defections from its staff. *Id.* at 1517-18.

The hospital, in *Boczar,* argued that its acts were legitimate peer review actions taken to address plaintiff's alleged unavailability or slow response to patient calls. *Id.* The hospital presented evidence of two incidents, in one of which plaintiff was charged with abandoning a patient in the emergency room. The court concluded that the peer review proceedings were pretextual and that the allegations of plaintiff's substandard patient care were either manufactured or exaggerated by defendant hospital and its staff. *Id.* at 1518, 1519.

In *Bolt,* the court reversed a directed verdict[15] for defendants and decided that reasonable people could disagree with the trial court's decision that there was no evidence of a conspiracy. If plaintiff can show that the "[hospital's] investigation's conclusions were so baseless that no reasonable medical practitioner, considering the same set of facts, could have reached those conclusions, then a factfinder could easily infer from that evidence that the hospital and its peer review committees intended to enter into an agreement designed to achieve an end not dictated by legitimate business concerns." *Id.* at 821. The court in *Bolt* first determined that a conspiracy to deny a

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[15] In directing a verdict for the defendants, the trial court refused to admit certain of plaintiff's proposed evidence that might have shown the existence of an unlawful conspiracy. The appellate court concluded that the trial court erred in excluding the plaintiff's proffered evidence and found that the evidence clearly tended to prove the existence of a contract, combination, or conspiracy.

doctor's hospital privileges would inure to the defendants' benefit. *Id.* at 820. The alleged co-conspirators argued that they had no rational economic motive for denying the plaintiff-physician's hospital privileges. The court was unconvinced and reasoned that "[i]f doctors in a hospital can exclude other doctors from practicing in that hospital, then obviously the remaining doctors can charge a higher price for their services." *Id.* at 820. Furthermore, denial of privileges at one hospital can negatively affect the decision of another hospital and can even have the effect of excluding the doctor from the profession as a whole. *Id.*

In addressing the second prong of the inquiry regarding whether plaintiff's proffered evidence tended to exclude the possibility that defendants acted legitimately and independently, the court in *Bolt* found that the evidence clearly tended to prove the existence of a conspiracy and that the alleged co-conspirators did not act legitimately and independently. *Id.* at 821. In reaching its conclusion, the court focussed on the following evidence: plaintiff proposed to show that certain members of one hospital's peer review committees knowingly suborned false evidence against him and that these individuals had personal motives for subverting the peer review proceedings; plaintiff intended to use a medical expert's testimony to attack some of the hospital's grounds for its revocation decision as being pretextual; plaintiff's medical expert would show that the hospital defendants based their position in part on two incidents that called plaintiff's medical or professional judgment into question; and plaintiff's expert would testify that he had reviewed the facts underlying the hospital's investigations and that no

reasonable medical practitioner would have come to the same conclusion reached by the hospital's investigators. *Id.* at 821. In *Islami,* the court stated that while it had some significant doubts about plaintiff's conspiracy theory, it was not in a position to weigh evidence at the summary judgment stage, and it concluded that plaintiff had pointed to sufficient factual allegations of the existence of a conspiracy. In reaching its decision, the court examined the following allegations: the hospital had a motive to take action against plaintiff for anticompetitive reasons; plaintiff opened his lab and immediately drew business from the hospital's lab because plaintiff provided safer and less costly tests; plaintiff competed both with the hospital and the doctors who ran the hospital's lab; defendant hospital petitioned its Medical Executive Committee to adopt a policy to permit use of plaintiff's lab only when the hospital lab did not provide the test needed; Dr. Waldorf, plaintiff's competitor and a general surgeon with staff privileges at defendant hospital, prompted review of plaintiff's charts and actually reviewed plaintiff's charts; Dr. Waldorf's involvement in the peer review process corresponded closely to the time when plaintiff's problems with his lab began; other doctors and the hospital joined in the review process prompted by Dr. Waldorf in order to eliminate plaintiff as a competitor; one defendant physician made comments about the removal of plaintiff's lab or there would be blood in the halls; another doctor made comments in his review about plaintiff's involvement with plaintiff's lab which could imply a nexus between the peer review process and the problems with plaintiff's lab. *Id.* at 1384-85.

In *Miller,* the court concluded that plaintiff provided evidence, which if believed by a jury, would show that the hospital's revocation of his privileges, although ostensibly for professional incompetence and unprofessional conduct, was motivated by the anticompetitive purpose of destroying plaintiff's competition with the hospital. In reaching its conclusion, the court relied on the following statements in affidavits: the hospital had expressed concern about plaintiff's competition; in one instance, the hospital interfered with plaintiff's recruitment of medical staff for plaintiff's proposed business; the hospital failed to terminate staff privileges of other physicians whose professional infractions were allegedly more substantial than plaintiff's; and the hearing process had irregularities and possible conflicts of interests, in that the presiding officer of the hearing was counsel for the hospital and the chairman was a doctor against whom plaintiff had previously filed charges of unethical conduct. *Id.*

See also Capital Imaging, 996 F.2d at 545 (the court found that plaintiff had presented sufficient circumstantial evidence that defendants had excluded it from a practice association in order to insulate defendants from increased competition); *Bhan,* 669 F. Supp. at 1016 (evidence taken together raises genuine issue of fact as to whether defendants acted in concert to exclude plaintiffs from the hospital; alleged participants may have had economic interests different from the hospital, and therefore, an independent personal stake in any decision by the hospital).

In this case, plaintiffs have submitted more evidence of the existence of a conspiracy than mere contacts and communications among defendants. *Compare Cooper,* 789

F.2d at 281-82. Plaintiffs do not ask that the existence of a conspiracy be inferred solely from defendants' anticompetitive conduct and the board's denial of privileges. *Compare Todorov,* 921 F.2d at 1458. Furthermore, the outside physicians who reviewed Dr. Brown's files were not entirely independent reviewers because they were affiliated with defendant PHS, and PHS did not conduct an extensive review of Dr. Brown's patient files before deciding to revoke her obstetrical privileges. *Compare Willman,* 34 F.3d at 612.

Plaintiffs have submitted evidence of anticompetitive motive. *See Islami,* 822 F. Supp. at 1384-85; *Miller,* 843 F.2d at 144; *compare Willman,* 34 F.3d at 612. In addition, plaintiffs have presented testimony revealing various LCMC staff members' dislike of Dr. Brown and anti-Semitic animus towards Dr. Brown. These were the staff members who instigated the review of Dr. Brown's patient files. Plaintiffs have also provided testimony with regard to PHS representatives' attempts to actively dissuade physicians from considering a practice with Dr. Brown. *See Miller,* 803 F.2d at 144.

Although the hospital's limited investigation may have revealed that Dr. Brown should have been monitored and required to obtain a consultation in certain cases, only defendants' expert Dr. Olds testified that on the basis of the reviewed files the hospital was justified in revoking Dr. Brown's obstetrical privileges. Drs. Hutchison and Aisenbrey, who reviewed Dr. Brown's first three files, did not discuss the need to revoke Dr. Brown's obstetrical privileges on the basis of those files. In fact, Dr. Hutchison stated merely that he "*would consider requesting* that [Dr. Brown] obtain obstetrical consultation

for any high risk [patient]. May 18, 1992 letter from Dr. Hutchison to Ms. Miller (emphasis added). Dr. Aisenbrey testified that the information provided to him was not sufficient to determine questions of privilege restrictions. Aisenbrey Dep. at p. 16. Plaintiffs' expert, Dr. Lindley, testified that while a reasonable physician could have concluded that Dr. Brown should obtain consultation in some cases, the files showing an alleged violation of the consultation requirement did not "reflect reasonable medical grounds for revoking her obstetrics privileges and does not justify the conclusion that Dr. Brown posed a threat to patient safety." *See Bolt*, 891 F.2d at 821 (plaintiffs' expert would testify that he had reviewed the facts underlying the hospital's investigations and that no reasonable medical practitioner would have reached the same conclusion as those reached by the hospital's reviewers). Finally, Dr. Leland Fellows, who reviewed Dr. Brown's application for obsterics privileges at a nearby hospital, stated that the record reflected that Dr. Brown had abided by the restriction on her hospital privileges and that he saw nothing in the transcript to indicate that Dr. Brown was incompetent or "which justified the denial of obstetrics privileges at LCMC or Gerald Champion."

Although it is a difficult decision, I conclude plaintiffs have presented evidence "that tends to exclude the possibility" that the alleged conspirators acted independently. I agree that legitimate quality of health concerns provide a permissible independent basis for restricting a physician's medical staff privileges. However, in this case, plaintiffs have submitted evidence that raises a genuine issue of material fact with regard to defendants' motivation for instigating the peer review proceedings.

Therefore, I conclude that defendants' motion for summary judgment on the merits of plaintiffs' antitrust claims under Section 1 of the Sherman Act should be denied.

VI. Defendants' Motion for Summary Judgment on the Merits of Plaintiffs' Claims under Section 2 of the Sherman Act:

Plaintiffs allege monopolization, attempt to monopolize and conspiracy to monopolize the market for obsterical services under § 2 of the Sherman Act. Section 2 of the Sherman Act provides in pertinent part, that "[e]very person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, . . . shall be deemed guilty of a felony." 15 U.S.C. § 2. Section 2 imposes liability for both concerted and unilateral acts. To prevail on a claim under § 2, plaintiffs must show that defendants "(1) possessed monopoly power in a relevant market, (2) willfully acquired or maintained that power, and (3) caused antitrust injury." *Bhan v. NME Hospitals, Inc.*, 669 F. Supp. 998, 1022 (E.D. Cal. 1987). To succeed on an attempted monopolization claim, plaintiffs must show that defendants: "(1) had a specific intent to monopolize a relevant market, (2) engaged in predatory or anticompetitive conduct, and (3) that there existed a dangerous probability of success." *Id.*

Defendants argue that summary judgment in their favor is justified because the existence of a legitimate

basis on which to revoke Dr. Brown's obstetrical privileges negates the specific anticompetitive intent necessary to prevail on claims of monopolization or attempt to monopolize. Defendants also assert that the absence of evidence to support a conspiracy claim makes a claim of conspiracy to monopolize untenable. Finally, defendants state that plaintiffs' § 2 claims should fail because defendants were incapable of causing the independent voting members of the LCMC Board to decide to revoke Dr. Brown's obstetrical privileges.

As I discussed *supra*, plaintiffs have presented evidence that calls into doubt whether defendants actions were supported by a legitimate independent basis when they reviewed Dr. Brown's files and decided to revoke her obstetrical privileges. In addition, plaintiffs have submitted evidence about the existence of a conspiracy that is sufficient to present to a jury. Furthermore, although the LCMC Board members who voted in favor of revocation were not Dr. Brown's competitors and had not themselves indicated any previous dislike of Dr. Brown, a jury could conclude that the peer review process was tainted when it was instigated by people who allegedly did not like Dr. Brown or who exhibited anti-Semitic animus towards Dr. Brown.

Based on this evidence, I conclude that there are genuine issues of material fact with regard to plaintiffs' claims for monopolization, attempted monopolization and conspiracy to monopolize. Hence, defendants' motion for summary judgment on the merits of plaintiffs' claims under § 2 of the Sherman Act should be denied.

VII. Defendants' Motion for Summary Judgment on the Merits of Plaintiffs' State Law Claims:

A. New Mexico Antitrust Act:

Courts should construe the New Mexico Antitrust Act harmoniously with the federal antitrust laws. *Clough v. Adventist Health Sys., Inc.*, 108 N.M. 801, 804 (1989). Therefore, summary judgment should be denied for all of the reasons discussed *supra*.

B. Breach of Contract:

Plaintiffs contend that the hospital's bylaws create an enforceable contract with the hospital's medical staff and that defendants breached the bylaws in a number of ways. The New Mexico Supreme Court has ruled that a hospital's bylaws constitute an implied contract. *Clough*, 108 N.M. at 806. The majority view among state courts is that a hospital's medical staff bylaws constitute a contract between the hospital and its medical staff. *Islami*, 822 F. Supp. at 1370.

Plaintiffs argue that defendants breached the hospital's bylaws in the following manner: (1) defendants revoked Dr. Brown's obstetrical privileges, in part, on the basis of one case where Dr. Brown treated a patient in her office while Article 5.1 of the bylaws provides that "Every practitioner practicing *in the Hospital* shall, in connection with such practice, be entitled to exercise only the clinical privileges specifically granted by the Board . . . " (emphasis added); (2) Article 6.1.1 of the bylaws defines only two grounds for revocation of privileges – substandard activities or professional conduct on the part of a

practitioner, or disruptive activities or professional conduct, including deficiencies in the practitioner's competency; however, defendants revoked Dr. Brown's obstetrical privileges because she failed to comply with the consultation requirement; (3) complaints against Dr. Brown were not submitted in writing as required by Article 6.1.1 of the bylaws; and (4) the three member Medical Executive Committee that reviewed the findings of the ad hoc panel consisted of two of the same members who sat on the three member ad hoc panel, contrary to Article 7.1.6 of the bylaws which implies that the Medical Executive Committee should provide an *independent* review of the ad hoc panel's findings.

Plaintiffs have presented evidence sufficient to show there are genuine issues of material of fact as to the breach of contract claims; therefore, defendants' motion for summary judgment on those claims should be denied.

C. Intentional Interference with Contractual and Prospective Contractual Business Relations:

In order to satisfy a claim of intentional interference with contractual and prospective contractual business relations, plaintiffs must show that one with a bad motive intentionally interfered with another's [prospective] contractual relations. *Schmitz v. Smentowski*, 109 N.M. 386, 396 (1990). Defendants argue that plaintiffs have failed to show proof of an improper means or an improper purpose on defendants' part. I have discussed *supra* the issue of whether defendants may have acted with a bad motive in instigating the peer review process and deciding to revoke Dr. Brown's obstetrical privileges on the basis of

the two files that were reviewed. The same evidence of bad motive raises a genuine issue of material fact and plaintiffs' claims of intentional interference with contractual and prospective contractual business relations. Ergo, defendants' motion for summary judgment on those claims should be denied as well.

D. Defamation:

New Mexico law defines defamatory communications as "those which tend to expose a person to contempt, to harm the person's reputation, or to discourage others from associating or dealing with her." N.M.U.J.I. 13-1007. Defendants argue that Dr. Brown's claims for defamation fail as a matter of law because the alleged statements "are clearly non-actionable rhetorical hyperbole or opinion" or "pueril (sic) name-calling." In contrast, plaintiffs allege that Dr. Beechie, Dr. Jackson, Dr. Williams and Nurse McCallum all defamed Dr. Brown in reference to her religion or ethnicity and/or her competency to practice medicine.

Plaintiffs have produced evidence sufficient to show a genuine issue of material fact with regard to whether some of the defendants or LCMC staff made statements about Dr. Brown that might have harmed her reputation, subjected her to contempt or discouraged others from dealing with her. Therefore, defendants' motion for summary judgment on plaintiffs' claims for defamation should be denied.

E. Unfair Trade Practices Act:

To invoke the Unfair Trade Practices Act ("UPTA"), plaintiffs must plead and prove:

> (1) that the party charged made an "oral or written statement, visual description or other representation," that was either false or misleading;
>
> (2) the false or misleading representation must have been "knowingly made in connection with the sale . . . of goods or services";
>
> (3) the conduct complained of must have occurred in the regular course of the representor's trade or commerce; and
>
> (4) the representation must have been of the type that "may, tends to or does, deceive or mislead any person."

N.M.S.A. 1978 § 57-12-2(D) (1994 Cum. Supp.).

Plaintiffs came forward with testimony that in at least one instance, Dr. Williams berated Dr. Brown in front of a patient and the patient's husband by saying "[i]f you don't know what you're doing, call someone who does" and "[y]ou are incompetent. You don't know what you're doing." Also, plaintiffs presented testimony that Dr. Jackson said, in reference to Dr. Brown, to a group of LCMC personnel at the hospital "[i]f you're not going to act in a responsible manner, then your license to kill and steal should be taken away." In response, defendants state that Dr. Jackson's alleged comment was at worst an exasperated remark.

Plaintiffs have offered evidence sufficient to show a genuine issue of material fact regarding plaintiffs' claims

of violations of the UTPA, and defendants' motion for summary judgment on the UTPA claims should be denied.

F. Prima Facie Tort:

In order to satisfy a claim for prima facie tort, plaintiffs must show that the tortfeasor acted maliciously with the intention to cause injury and without justification or with insufficient justification. *Schmitz*, 109 N.M. at 395. Defendants again assert that they revoked Dr. Brown's obstetrical privileges with ample medical justification. I have discussed *supra* defendants' claimed justification for the revocation of Dr. Brown's obstetrical privileges. Based on that reasoning, I conclude that a genuine issue of material fact exists and that defendants' motion for summary judgment on plaintiffs' claims of prima face tort should be denied. However, if at the close of the evidence, plaintiff's proof is susceptible to submission under another category of tort, I will submit the action on that cause and not under prima facie tort. *Id.* at 396. The theory underlying prima facie tort is to provide a remedy "for intentionally committed acts that do not fit within the contours of an accepted tort . . . " *Id.*

VIII. Plaintiffs' Motion in Limine:

Rule 402 of the Federal Rules of Evidence states that: "[e]vidence that is not relevant is not admissible." Plaintiffs contend that evidence of Dr. Brown's competence or skills as a physician is not relevant under FRE 402 and that defendants should not be allowed to introduce or

rely on any "competence" evidence to justify the hospital's revocation of Dr. Brown's obstetrical privileges. In support of their argument, plaintiffs submit evidence that defendants have stated on several occasions that Dr. Brown's obstetrical privileges were revoked due to her alleged failure to comply with an agreement to obtain consultation and not because of her level of competence or skill. Plaintiffs also argue that defendants should be equitably estopped from litigating Dr. Brown's competence after allegedly admitting that her competence was not at issue in the privileges process.

Defendants agree that they do not intend to offer evidence questioning Dr. Brown's general medical knowledge and skill. Defendants stipulated that Dr. Brown is a competent family practitioner, able to handle certain types of obstetrical patients on her own without seeking consultation. Transcript of Motion Hearing held November 22, 1994 at p. 11. Therefore, evidence of Dr. Brown's general competence as a physician is not relevant and should not be admissible.

However, defendants contend that the imposition of the consultation requirement and Dr. Brown's alleged violation of the consultation requirement relate to the extent of her clinical competence. In addition, defendants argue that to overcome plaintiff's allegation of a Sherman Act § 1 violation, defendants can attempt to show that the revocation of Dr. Brown's obstetrical privileges was due to the hospital's pursuit of its legitimate interest in health care and patient welfare. Defendants argue that such a defense is also relevant to plaintiffs' claims under § 2 of the Sherman Act and some of plaintiffs' pendent state law claims.

I conclude that evidence of Dr. Brown's competence is relevant and admissible in so far as defendants can show it relates to their decision to impose the consultation requirement and to revoke Dr. Brown's obstetrical privileges because she did not comply with the requirement. Plaintiffs have already attempted to show that Dr. Brown was competent in her decisions whether or not to obtain consultations. Plaintiffs' expert, Dr. Lindley, stated that he had reviewed approximately fifty of Dr. Brown's OB patients "for the purpose of judging Dr. Brown's competence in obstetrics." Affidavit of Lindley at p.1. Dr. Lindley also stated that he believed such a chart review was a necessary step "in fairly assessing the professional competence" of Dr. Brown or in determining whether her pattern of seeking consultation warrants concern. *Id.* at p.2. Both parties should be allowed to introduce evidence of Dr. Brown's competence to recognize the need for consultations in high risk cases.

IT IS THEREFORE ORDERED that:

(1) defendants' motion for partial summary judgment based on immunity under the HCQIA and ROIA for their acts that lead to the revocation of Dr. Brown's obstetrical privileges and for their actions in reporting Dr. Brown's revocation of obstetrical privileges to the data bank is DENIED;

(2) defendants' motion for summary judgment on the merits of plaintiffs' federal antitrust and state law claims is DENIED; and

(3) plaintiffs' motion in limine to preclude defendants from introducing or relying on evidence of Dr. Brown's competence in certain cases is DENIED.

/s/ James A. Parker
UNITED STATES DISTRICT COURT

APPENDIX D

CHAPTER 117 – ENCOURAGING GOOD FAITH PROFESSIONAL REVIEW ACTIVITIES

§ 11101. Findings

The Congress finds the following:

(1) the increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those than can be undertaken by any individual State.

(2) There is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance.

(3) This nationwide problem can be remedied through effective professional peer review.

(4) The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review.

(5) There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.

SUBCHAPTER I – PROMOTION OF PROFESSIONAL REVIEW ACTIVITIES

§ 11111. Professional review

(a) In general

(1) Limitation on damages for professional review actions

If a professional review action (as defined in section 11151(9) of this title) of a professional review body meets all the standards specified in section 11112(a) of this title, except as provided in subsection (b) of this section –

(A) the professional review body,

(B) any person acting as a member or staff to the body,

(C) any person under a contract or other formal agreement with the body, and

(D) any person who participates with or assists the body with respect to the action,

shall not be liable in damages under any law of the United States or of any State (or political subdivision thereof) with respect to the action. The preceding sentence shall not apply to damages under any law of the United States or any State relating to the civil rights of any person or persons, including the Civil Rights Act of 1964, 42 U.S.C. 2000e, et seq. and the Civil Rights Acts, 42 U.S.C. 1981, et seq. Nothing in this paragraph shall prevent the United States or any Attorney General of a State from bringing an action, including an action under section 15c of Title 15, where such an action is otherwise authorized.

(2) Protection for those providing information to professional review bodies

Notwithstanding any other provision of law, no person (whether as a witness or otherwise) providing information to a professional review body regarding the competence or professional conduct of a physician shall be held, by reason of having provided such information, to be liable in damages under any law of the United States or of any State (or political subdivision thereof) unless such information is false and the person providing it knew that such information was false.

(b) Exception

If the Secretary has reason to believe that a health care entity has failed to report information in accordance with section 11133(a) of this title, the Secretary shall conduct an investigation. If, after providing notice of noncompliance, an opportunity to correct the noncompliance, and an opportunity for a hearing, the Secretary determines that a health care entity has failed substantially to report information in accordance with section 11133(a) of this title, the Secretary shall publish the name of the entity in the Federal Register. The protections of subsection (a)(1) of this section shall not apply to an entity the name of which is published in the Federal Register under the previous sentence with respect to professional review actions of the entity commenced during the 3-year period beginning 30 days after the date of publication at the name.

(c) Treatment under State laws

(1) Professional review actions taken on or after October 14, 1989

Except as provided in paragraph (2), subsection (a) of this section shall apply to State laws in a State only for professional review actions commenced on or after October 14, 1989.

(2) Exceptions

(A) State early opt-in

Subsection (a) of this section shall apply to State laws in a State for actions commenced before October 14, 1989, if the State by legislation elects such treatment.

(B) Effective date of election

An election under State law is not effective, for purposes of[1], for actions commenced before the effective date of the State law, which may not be earlier than the date of the enactment of that law.

§ 11112. Standards for professional review actions

(a) In general

For purposes of the protection set forth in section 11111(a) of this title, a professional review action must be taken –

(1) in the reasonable belief that the action was in the furtherance of quality health care,

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[1] So in original. Probably should be "for purposes of subparagraph (A)."

(2) after a reasonable effort to obtain the facts of the matter,

(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

A professional review action shall be presumed to have met the proceeding standards necessary for the protection set out in section 11111(a) of this title unless the presumption is rebutted by a preponderance of the evidence.

(b) Adequate notice and hearing

A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) of this section with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):

(1) Notice of proposed action

The physician has been given notice stating –

(A)(i) that a professional review action has been proposed to be taken against the physician,

(ii) reasons for the proposed action,

(B)(i) that the physician has the right to request a hearing on the proposed action,

(ii) any time limit (of not less than 30 days) within which to request such a hearing, and

(C) a summary of the rights in the hearing under paragraph (3).

(2) Notice of hearing

If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating –

(A) the place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, and

(B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.

(3) Conduct of hearing and notice

If a hearing is requested on a timely basis under paragraph (1)(B) –

(A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity) –

(i) before an arbitrator mutually acceptable to the physician and the health care entity,

(ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or

(iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;

(B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;

(C) in the hearing the physician involved has the right –

(i) to representation by an attorney or other person of the physician's choice,

(ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,

(iii) to call, examine, and cross-examine witnesses,

(iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and

(v) to submit a written statement at the close of the hearing; and

(D) upon completion of the hearing, the physician involved has the right –

(i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and

(ii) to receive a written decision of the health care entity, including a statement of the basis for the decision.

A professional review body's failure to meet the conditions described in this subsection shall not, in itself, constitute failure to meet the standards of subsection (a)(3) of this section.

(c) Adequate procedures in investigations or health emergencies

For purposes of section 11111(a) of this title, nothing in this section shall be construed as –

(1) requiring the procedures referred to in subsection (a)(3) of this section –

(A) where there is no adverse professional review action taken, or

(B) in the case of a suspension or restriction of clinical privileges, for a period of not longer than 14 days, during which an investigation is being conducted to determine the need for a professional review action; or

(2) precluding an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual.

SUBCHAPTER II – REPORTING OF INFORMATION

§ 11131. Requiring reports on medical malpractice payments

(a) In general

Each entity (including an insurance company) which makes payment under policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim shall report, in accordance with section 11134 of this title, information respecting the payment and circumstances thereof.

(b) Information to be reported

The information to be reported under subsection (a) of this section includes –

(1) the name of any physician or licensed health care practitioner for whose benefit the payment is made,

(2) the amount of the payment,

(3) the name (if known) of any hospital with which the physician or practitioner is affiliated or associated,

(4) a description of the acts or omissions and injuries or illnesses upon which the action or claim was based, and

(5) such other information as a Secretary determines is required for appropriate interpretation of information reported under this section.

(c) Sanctions for failure to report

Any entity that fails to report information on a payment required to be reported under this section shall be subject to a civil money penalty of not more than $10,000 for each such payment involved. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1320a-7a of this title are imposed and collected under that section.

(d) Report on treatment of small payments

The Secretary shall study and report to Congress, not later than two years after November 14, 1986, on whether information respecting small payments should continue to be required to be reported under subsection (a) of this

section and whether information respecting all claims made concerning a medical malpractice action should be required to be reported under such subsection.

§ 11132. Reporting of sanctions taken by Boards of Medical Examiners

(a) In general

(1) Actions subject to reporting

Each Board of Medical Examiners –

(A) which revokes or suspends (or otherwise restricts) a physician's license or censures, reprimands, or places on probation a physician, for reasons relating to the physician's professional competence or professional conduct, or

(B) to which a physician's license is surrendered,

shall report, in accordance with section 11134 of this title, the information described in paragraph (2).

(2) Information to be reported

The information to be reported under paragraph (1) is –

(A) the name of the physician involved,

(B) a description of the acts or omissions or other reasons (if known) for the revocation, suspension, or surrender of license, and

(C) such other information respecting the circumstances of the action or surrender as the Secretary deems appropriate.

(b) Failure to report

If, after notice of noncompliance and providing opportunity to correct noncompliance, the Secretary determines that a Board of Medical Examiners has failed to report information in accordance with subsection (a) of this section, the Secretary shall designate another qualified entity for the reporting of information under section 11133 of this title.

§ 11133. Reporting of certain professional review actions taken by health care entities

(a) Reporting by health care entities

(1) On physicians

Each health care entity which –

(A) takes a professional review action that adversely affects the clinical privileges of a physician for a period longer than 30 days;

(B) accepts the surrender of clinical privileges of a physician –

(i) while the physician is under an investigation by the entity relating to possible incompetence or improper professional conduct, or

(ii) in return for not conducting such an investigation or proceeding; or

(C) in the case of such an entity which is a professional society, takes a professional review action which adversely affects the membership of a physician in the society,

shall report to the Board of Medical Examiners, in accordance with section 11134(a) of this title, the information described in paragraph (3).

(2) Permissive reporting on other licensed health care practitioners

A health care entity may report to the Board of Medical Examiners, in accordance with section 11134(a) of this title, the information described in paragraph (3) in the case of a licensed health care practitioner who is not a physician, if the entity would be required to report such information under paragraph (1) with respect to the practitioner if the petitioner were a physician.

(3) Information to be reported

The information to be reported under this subsection is –

(A) the name of the physician or practitioner involved,

(B) a description of the acts or omissions or other reasons for the action or, if known, for the surrender, and

(C) such other information respecting the circumstances of the action or surrender as the Secretary deems appropriate.

(b) Reporting by Board of Medical Examiners

Each Board of Medical Examiners shall report, in accordance with section 11134 of this title, the information reported to it under subsection (a) of this section and known instances of a health care entity's failure to report information under subsection (a)(1) of this section.

(c) Sanctions

(1) Health care entities

A health care entity that fails substantially to meet the requirement of subsection (a)(1) of this section shall lose the protections of section 11111(a)(1) of this title if the Secretary publishes the name of the entity under section 11111(b) of this title.

(2) Board of Medical Examiners

If, after notice of noncompliance and providing an opportunity to correct noncompliance, the Secretary determines that a Board of Medical Examiners has failed to report information in accordance with subsection (b) of this section, the Secretary shall designate another qualified entity for the reporting of information under subsection (b) of this section.

(d) References to Board of Medical Examiners

Any reference in this subchapter to a Board of Medical Examiners includes, in the case of a Board in a State that fails to meet the reporting requirements of section 11132(a) of this title or subsection (b) of this section, a reference to such other qualified entity as the Secretary designates.

§ 11134. Form of reporting

(a) Timing and form

The information required to be reported under sections 11131, 11132(a), and 11133 of this title shall be reported regularly (but not less often than monthly) and in such form and manner as the Secretary prescribes. Such information shall first be required to be reported on

a date (not later than one year after November 14, 1986) specified by the Secretary.

(b) To whom reported

The information required to be reported under sections 11131, 11132(a), and 11133(b) of this title shall be reported to the Secretary, or, in the Secretary's discretion, to an appropriate private or public agency which has made suitable arrangements with the Secretary with respect to receipt, storage, protection of confidentiality, and dissemination of the information under this subchapter.

(c) Reporting to State licensing boards

(1) Malpractice payments

Information required to be reported under section 11131 of this title shall also be reported to the appropriate State licensing board (or boards) in the State in which the medical malpractice claim arose.

(2) Reporting to other licensing boards

Information required to be reported under section 11133(b) of this title shall also be reported to the appropriate State licensing board in the State in which the health care entity is located if it is not otherwise reported to such board under subsection (b) of this section.

§ 11135. Duty of hospitals to obtain information

(a) In general

It is the duty of each hospital to request from the Secretary (or the agency designated under section 11134(b) of this title), on and after the date information is

first required to be reported under section 11134(a) of this title) –[1]

(1) at the time a physician or licensed health care practitioner applies to be on the medical staff (courtesy or otherwise) of, or for clinical privileges at, the hospital, information reported under this subchapter concerning the physician or practitioner, and

(2) once every 2 years information reported under this subchapter concerning any physician or such practitioner who is on the medical staff (courtesy or otherwise) of, or has been granted clinical privileges at, the hospital.

A hospital may request such information at other times.

(b) Failure to obtain information

With respect to a medical malpractice action, a hospital which does not request information respecting a physician or practitioner as required under subsection (a) of this section is presumed to have knowledge of any information reported under this subchapter to the Secretary with respect to the physician or practitioner.

(c) Reliance on information provided

Each hospital may rely upon information provided to the hospital under this chapter and shall not be held liable for such reliance in the absence of the hospital's knowledge that the information provided was false.

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[1] So in original. The closing parenthesis probably should not appear.

§ 11136. Disclosure and correction of information

With respect to the information reported to the Secretary (or the agency designated under section 11134(b) of this title) under this subchapter respecting a physician or other licensed health care practitioner, the Secretary shall, by regulation, provide for –

(1) disclosure of the information, upon request, to the physician or practitioner, and

(2) procedures in the case of disputed accuracy of the information.

§ 11137. Miscellaneous provisions

(a) Providing licensing boards and other health care entities with access to information

The Secretary (or the agency designated under section 11134(b) of this title) shall, upon request, provide information reported under this subchapter with respect to a physician or other licensed health care practitioner to State licensing boards, to hospitals, and to other health care entities (including health maintenance organizations) that have entered (or may be entering) into an employment or affiliation relationship with the physician or practitioner or to which the physician or practitioner has applied for clinical privileges or appointment to the medical staff.

(b) Confidentiality of information

(1) In general

Information reported under this subchapter is considered confidential and shall not be disclosed (other than to the physician or practitioner involved)

except with respect to professional review activity, as necessary to carry out subsections (b) and (c) of section 11135 of this title (as specified in regulations by the Secretary), or in accordance with regulations of the Secretary promulgated pursuant to subsection (a) of this section. Nothing in this subsection shall prevent the disclosure of such information by a party which is otherwise authorized, under applicable State law, to make such disclosure. Information reported under this subchapter that is in a form that does not permit the identification of any particular health care entity, physician, other health care practitioner, or patient shall not be considered confidential. The Secretary (or the agency designated under section 11134(b) of this title), on application by any person, shall prepare such information in such form and shall disclose such information in such form.

(2) Penalty for violations

Any person who violates paragraph (1) shall be subject to a civil money penalty of not more than $10,000 for each such violation involved. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1320a-7a of this title are imposed and collected under that section.

(3) Use of information

Subject to paragraph (1), information provided under section 11135 of this title and subsection (a) of this section is intended to be used solely with respect to activities in the furtherance of the quality of health care.

(4) Fees

The Secretary may establish or approve reasonable fees for the disclosure of information under this section or section 11136 of this title. The amount of

such a fee may not exceed the costs of processing the requests for disclosure and of providing such information. Such fees shall be available to the Secretary (or, in the Secretary's discretion, to the agency designated under section 11134(b) of this title) to cover such costs.

(c) Relief from liability for reporting

No person or entity (including the agency designated under section 11134(b) of this title) shall be held liable in any civil action with respect to any report made under this subchapter (including information provided under subsection (a) of this section[1] without knowledge of the falsity of the information contained in the report.

(d) Interpretation of information

In interpreting information reported under this subchapter, a payment in settlement of a medical malpractice action or claim shall not be construed as creating a presumption that medical malpractice has occurred.

SUBCHAPTER III – DEFINITIONS AND REPORTS

§ 11151. Definitions

In this chapter:

(1) The term "adversely affecting" includes reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in a health care entity.

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[1] So in original. Probably should be followed by a closing parenthesis.

(2) The term "Board of Medical Examiners" includes a body comparable to such a Board (as determined by the State) with responsibility for the licensing of physicians and also includes a subdivision of such a Board or body.

(3) The term "clinical privileges" includes privileges, membership on the medical staff, and the other circumstances pertaining to the furnishing of medical care under which a physician or other licensed health care practitioner is permitted to furnish such care by a health care entity.

(4)(A) The term "health care entity" means –

(i) a hospital that is licensed to provide health care services by the State in which it is located,

(ii) an entity (including a health maintenance organization or group medical practice) that provides health care services and that follows a formal peer review process for the purpose of furthering quality health care (as determined under regulations of the Secretary), and

(iii) subject to subparagraph (B), a professional society (or committee thereof) of physicians or other licensed health care practitioners that follows a formal peer review process for the purpose of furthering quality health care (as determined under regulations of the Secretary).

(B) the term "health care entity" does not include a professional society (or committee thereof) if, within the previous 5 years, the society has been found by the Federal Trade Commission or any court to have engaged in any anti-competitive practice which had the effect of restricting the practice of licensed health care practitioners.

(5) The term "hospital" means an entity described in paragraphs (1) and (7) of section 1395x(e) of this title.

(6) The terms "licensed health care practitioner" and "practitioner" mean, with respect to a State, an individual (other than a physician) who is licensed or otherwise authorized by the State to provide health care services.

(7) The term "medical malpractice action or claim" means a written claim or demand for payment based on a health care provider's furnishing (or failure to furnish) health care services, and includes the filing of a cause of action, based on the law of tort, brought in any court of any State or the United States seeking monetary damages.

(8) The term "physician" means a doctor of medicine or osteopathy or a doctor of dental surgery or medical dentistry legally authorized to practice medicine and surgery or dentistry by a State (or any individual who, without authority holds himself or herself out to be so authorized).

(9) The term "professional review action" means an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician. Such term includes a formal decision of a professional review body not to take an action or make a recommendation described in the previous sentence and also includes professional review activities relating to a professional

review action. In this chapter, an action is not considered to be based on the competence or professional conduct of a physician if the action is primarily based on –

(A) the physician's association, or lack of association, with a professional society or association,

(B) the physician's fees or the physician's advertising or engaging in other competitive acts intended to solicit or retain business,

(C) the physician's participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis,

(D) a physician's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, a member or members of a particular class of health care practitioner or professional, or

(E) any other matter than does not relate to the competence or professional conduct of a physician.

(10) The term "professional review activity" means an activity of a health care entity with respect to an individual physician –

(A) to determine whether the physician may have clinical privileges with respect to, or membership in, the entity,

(B) to determine the scope or conditions of such privileges or membership, or

(C) to change or modify such privileges or membership.

(11) The term "professional review body" means a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the medical staff of such an entity when assisting the governing body in a professional review activity.

(12) The term "Secretary" means the Secretary of Health and Human Services.

(13) The term "State" means the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(14) The term "State licensing board" means, with respect to a physician or health care provider in a State, the agency of the State which is primarily responsible for the licensing of the physician or provider to furnish health care services.

Supreme Court, U.S.
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(2)

No. 96-1365

In The

Supreme Court of the United States

October Term, 1996

VALERIE MILLER and VICKIE WILLIAMS, D.O.,

Petitioners,

vs.

ARLENE M. BROWN, M.D., and
FAMILY PRACTICE ASSOCIATES, P.C.,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Tenth Circuit

RESPONDENTS' BRIEF IN OPPOSITION

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19 pp

QUESTIONS PRESENTED

1. Did Dr. Brown present sufficient evidence to permit a reasonable jury to find that, in revoking Dr. Brown's obstetrics privileges, the hospital failed to make "a reasonable effort to obtain the facts of the matter," as required by 42 U.S.C. § 11112(a)(2), in view of the fact that the revocation followed a review of only two charts, which, by the hospital's admission, did not reflect any departure from the standard of care?

2. Did Dr. Brown present sufficient evidence to permit a reasonable jury to find that Ms. Miller reported the revocation of Dr. Brown's privileges as based on "Incompetence/Malpractice/Negligence" knowing that the report was false, such that Ms. Miller was not entitled to immunity under 42 U.S.C. § 11137(c)?

RULE 29.6 LISTING

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RESPONDENTS' BRIEF IN OPPOSITION

Respondents Dr. Arlene M. Brown, M.D. and Family Practice Associates, P.C. (collectively, "Dr. Brown") respectfully request that the Court deny the petition for writ of certiorari submitted on behalf of Ms. Valerie Miller and Dr. Vickie Williams, D.O. (collectively "the Petitioners"). The Petitioners' attempt to depict the Tenth Circuit's decision as creating a split among the circuits concerning the treatment of conflicting expert testimony under 42 U.S.C. § 11112(a)(2) of the Health Care Quality Improvement Act, 42 U.S.C. §§ 11101-11152 ("HCQIA")[1] fails for two reasons.

First, the Petitioners' argument does not account for the unique facts of Dr. Brown's case. One of the central issues at trial was whether the hospital made a reasonable effort to obtain the facts concerning Dr. Brown's knowledge and skill in obstetrics. Without such an effort, the Petitioners are not entitled to HCQIA immunity. As

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[1] 42 U.S.C. § 11112(a) provides HCQIA immunity if the professional review action was taken:

> (1) in the reasonable belief that the action was in the furtherance of quality health care,
>
> (2) after a reasonable effort to obtain the facts of the matter,
>
> (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
>
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

explained below, no other court has addressed HCQIA immunity in connection with a revocation of hospital privileges based on a review of only two charts which, by the hospital's admission, reflected no departure from the standard of care. No other case presents a comparable failure to make a reasonable effort to obtain the facts.

The Tenth Circuit correctly applied the "objective reasonableness" standard in holding that these facts would allow a reasonable jury to conclude that the hospital had failed to make "a reasonable effort to obtain the facts of the matter," as required by § 11112(a)(2). For this reason alone, the Tenth Circuit's opinion cannot be fairly characterized as creating a split among the circuits. Instead, the Tenth Circuit addressed and correctly resolved an ordinary "substantial evidence" issue.

Furthermore, the Petitioners' attempt to portray a split rests on precedents applying distinguishable statutory language. The cases the Petitioners rely on articulate a rule for conflicting expert testimony relating to subsections 1 and 4 of § 42 U.S.C. § 11112(a), which both include a "reasonable belief" element. The Tenth Circuit's decision applies subsection 2 of § 11112(a), which contains no "reasonable belief" language and considers only whether the peer review action was taken "after a reasonable effort to obtain the facts of the matter." The Petitioners' efforts to depict a split thus improperly blurs the differences in the language of subsection 2 and subsections 1 and 4.

Finally, the Petitioners seek review of the Tenth Circuit's denial of HCQIA immunity under 42 U.S.C. § 11137(c) for Ms. Miller's report of the revocation of Dr.

Brown's privileges to the National Practitioner Data Bank. The Petitioners do not claim that this part of the Tenth Circuit's decision creates a split among the circuits. Instead, the Petitioners question whether the evidence in this case would allow a reasonable jury to conclude that Ms. Miller made the "Incompetence/Malpractice/ Negligence" report knowing of its falsity. As demonstrated below, the record supports the jury's conclusion that Ms. Miller knew her report was false.

REASONS FOR DENYING THE PETITION

I. The Tenth Circuit's Decision to Deny Immunity for the Revocation of Dr. Brown's Privileges Creates No Split Among the Circuits.

A. The Unique Facts of This Case Dictated Its Outcome.

The Petitioners' argument that the Tenth Circuit's decision creates a split among the circuits disregards the unique facts in this case. The decision to revoke Dr. Brown's obstetrics privileges rested on a review of only two patient charts. App. 20, 35. Dr. Brown's expert, Dr. Lindley, testified that Dr. Brown abided by the consultation requirement,[2] but that in any event, a review of only

[2] Dr. Lindley testified that, in one of the two cases reviewed, Dr. Brown could not have violated the consultation requirement, which was imposed as a restriction on Dr. Brown's hospital privileges, because Dr. Brown treated the patient in question in Dr. Brown's office and not at the hospital. Dr. Brown was therefore not exercising her hospital privileges. The

two charts did not provide a reasonable basis for revoking Dr. Brown's obstetrics privileges or amount to a reasonable effort to obtain the facts. App. 35, 36. Dr. Lindley reviewed the charts for all of the obstetrics patients Dr. Brown treated in the six-month period before her privileges were revoked, a sample consisting of 50 charts. Dr. Lindley conducted this review because he wanted enough information to assess whether Dr. Brown possessed the knowledge and skill to recognize high risk cases. App. 36.

After conducting the 50 chart review, Dr. Lindley had no questions about Dr. Brown's ability to recognize high risk cases and saw no instances where she failed to get a necessary consultation. No other witness provided testimony based on a review of the 50 charts Dr. Lindley examined or a comparable sample. No witness expressly testified that a review confined to the two charts at issue amounted to a reasonable effort to assess Dr. Brown's skills and knowledge in obstetrics. In this area, Dr. Lindley's conclusions were unrebutted.[3]

At trial, the Petitioners' experts confined their conclusions to whether the two charts reviewed reasonably supported the revocation of Dr. Brown's privileges. They did not attempt to defend the limited scope of review. Thus, their testimony addressed only subsection 1, and

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Petitioners' experts agreed. The hospital's "extraterritorial" enforcement of the restriction on Dr. Brown's hospital privileges adds another unique factual dimension to Dr. Brown's case.

[3] The Petitioners' attempt to posit a split among the circuits based on a disagreement between expert witnesses is especially unpersuasive in view of their decision not to offer their own expert conclusions based on a review of the 50 charts Dr. Lindley reviewed.

perhaps subsection 4, of § 11112(a), concerning whether the hospital had a "reasonable belief that the action was in furtherance of quality health care" and whether the hospital had a "reasonable belief that the action was warranted." Despite Dr. Lindley's testimony, the Petitioners' experts did not expressly address whether there had been "a reasonable effort to obtain the facts of the matter."

One of the Petitioners' medical experts, Dr. Messer, agreed that, in making privileges decisions, a reviewer should have as much information about a physician's skill and abilities as possible and that a review of 50 charts is therefore preferable to a review of only two. Dr. Messer reviewed the 50 charts examined by Dr. Lindley, but offered no opinions based on them. Dr. Hutchinson, an OB-GYN specialist testifying for the Petitioners, agreed that two or three charts did not provide a representative sample of Dr. Brown's obstetrics practice and would not provide a sufficient basis for conclusions about Dr. Brown's knowledge of obstetrics.

Dr. Olds, another of the Petitioners' medical experts, admitted that, in his own experience as a reviewer in license revocation proceedings, he examined 25 to 50 preselected "problem" charts. He testified that, in his own experience, revocations based on single cases have occurred, depending on "how bad" the case was.[4]

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[4] The testimony from Drs. Olds, Hutchison, and Messer about the scope of reviews in their real life experiences as peer review participants contrasts sharply with the Petitioners' arguments about the sufficiency of the chart review in Dr. Brown's case. This contrast by itself would allow a reasonable jury to decide that the review was insufficient, irrespective of

The evidence concerning "how bad" Dr. Brown's two cases were also makes the revocation of Dr. Brown's privileges unique among peer review decisions. The hospital revoked Dr. Brown's obstetrics privileges after reviewing only two charts which the hospital itself recognized as not representing any departures from the relevant standard of care. App. 38, 39-40, 70, 71. For example, the hospital's counsel, Mr. Lasater, wrote to Dr. Brown's lawyers shortly after the revocation that

> the issue was not whether, on these occasions [the two charts reviewed], Dr. Brown met the minimum standards required of a family practitioner taking care of a high risk patient. The issue, I believe, was whether Dr. Brown had failed to comply with her agreement to obtain consultations for high risk patients.
>
> App. 86.

Petitioner Dr. Williams agreed at trial that Mr. Lasater's distinction drew a "bright line" separating standard of care issues and the question whether Dr. Brown complied with the consultation requirement. The hospital's Board members agreed. In the Board's view, Dr. Brown's case presented a question of whether Dr. Brown had lived up to her promise, rather than a medical issue. App. 71. Also, Petitioner Dr. Williams testified that she had "no heartburn" with the medical management of the patient Dr. Brown treated at the hospital. App. 70.

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the conflict between the experts. *See, e.g., Barefoot v. Estelle*, 463 U.S. 880, 902-03 (1983); *Powers v. Bayliner Marine Corp.*, 83 F.3d 789, 797-98 (6th Cir.), *cert. denied*, 117 S. Ct. 481 (1996).

The Petitioners have cited no decisions in which a court has upheld a claim for HCQIA immunity under 42 U.S.C. § 11112(a)(2) based on a comparably restricted scope of review. The trial court carefully canvassed HCQIA precedents, contrasting the extent of review and the evidence of deficient or substandard care in those precedents with the review of two charts in Dr. Brown's case. App. 36-37, 82-85.[5] The narrow scope of review and

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[5] The trial court compared the scope of review in Dr. Brown's case with *Mathews v. Lancaster General Hospital*, 883 F. Supp. 1016, 1035 (E.D. Pa. 1995), *aff'd*, 87 F.3d 624 (3rd Cir. 1996); *Monroe v. AMI Hospitals of Texas, Inc.*, 1994 LEXIS 17755 (S.D. Tex., Oct. 27, 1994); *Willman v. Heartland Hospital East*, 34 F.3d 605 (8th Cir. 1994), *cert. denied*, 115 S. Ct. 1361 (1995); *Imperial v. Suburban Hospital Board of Trustees*, 37 F.3d 1026 (4th Cir. 1994); *Bryan v. Holmes Regional Medical Center*, 33 F.3d 1318, 1332 (11th Cir. 1994), *cert. denied*, 115 S. Ct. 1363 (1995); *Rooney v. Medical Center Hospital of Chillicothe, Ohio*, 1994 LEXIS 7420 (S.D. Ohio 1994); *Austin v. McNamara*, 979 F.2d 728 (9th Cir. 1992); *Oksanen v. Page Memorial Hospital*, 945 F.2d 696 (4th Cir. 1991), *cert. denied*, 502 U.S. 1074 (1992); *Fobbs v. Holy Cross Health System Corp.*, 789 F. Supp. 1054 (E.D. Cal. 1992), *aff'd in part and reversed in part*, 29 F.3d 1439, *cert. denied*, 115 S. Ct. 936 (1995); *Smith v. Ricks*, 798 F. Supp. 605 (N.D. Cal. 1992), *aff'd*, 31 F.3d 1478 (9th Cir. 1994), *cert. denied*, 115 S. Ct. 1400 (1995); *Islami v. Covenant Medical Center, Inc.*, 822 F. Supp. 1361, 1365 (N.D. Iowa 1992). The same comparison with more recent cases confirms the uniquely narrow scope of review in Dr. Brown's case. *See Goodwich v. Sinai Hospital of Baltimore, Inc.*, 680 A.2d 1067 (Md. 1996) (revocation of privileges followed years of discussion and correspondence with physician about patient care problems, physician's repeated failures to heed written warnings about necessity of obtaining second opinions, and failure to obtain second opinions in more than a dozen high risk cases); *Johnson v. Greater Southeast Community Hospital Corp.*, 1996 WL 377147 (D.D.C. June 24, 1996) (review of seven cases over a nine month peer review process revealed very serious quality of care

the defendants' admissions that the treatment reflected in the two charts reviewed did not depart from the standard of care distinguish this case from the decisions Petitioners cite. Thus, no split among the circuits exists because no other court has considered HCQIA immunity under 42 U.S.C. § 11112(a)(2) in light of a similarly limited scope of review, with comparable concessions that the case against the plaintiff/practitioner represented no departures from the standard of care, and with a comparable lack of rebuttal to the plaintiff's expert's conclusions.

The Tenth Circuit and the district court correctly applied the standard controlling the availability of HCQIA immunity in determining that, based on these facts, Dr. Brown had presented sufficient evidence for a reasonable jury to find, by a preponderance of the evidence, that the peer review action was not taken after a "reasonable effort to obtain the facts of the matter." App. 20. In doing so, the Tenth Circuit and the district court applied an objective standard of reasonableness. App. 19, 21, n.9 (applying objective standard articulated in *Mathews v. Lancaster General Hospital*, 87 F.3d 624, 634 (3d Cir. 1996) and *Austin v. McNamara*, 979 F.2d 728, 734 (9th Cir. 1992)), App. 34-37. The outcome of Dr. Brown's case thus derived from the unique facts it presented, not from some aberrant misapplication of the law.

Also, the unique facts of this case defeat the Petitioners' claim to HCQIA immunity irrespective of

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concerns related to potentially life threatening surgical complications and several major surgeries without adequate indications).

whether conflicting expert testimony about the reasonableness of the scope of inquiry creates a triable issue of fact under § 11112(a)(2). The Petitioners' position disregards the fact that the evidence in this case sufficed to permit the jury to find that Dr. Brown had overcome all three of the disputed HCQIA elements. *See* App. 21, n.9, App. 32-37.

B. The Petitioners' Argument Rests on Distinguishable Precedents.

In addition to ignoring the unique facts in Dr. Brown's case, the Petitioners overlook the difference between the statutory basis for the Tenth Circuit's decision and for the decisions they rely on in positing a split among the circuits. The Petitioners have cited no decisions in which a court analyzing the "reasonable effort to obtain the facts" requirement imposed by § 11112(a)(2) has held that a disagreement among experts is insufficient to create a triable fact question.[6] For this reason, the Tenth Circuit's decision does not conflict with any other circuit court precedents, including those analyzing the effect of conflicting expert testimony under the portions of § 11112(a) which include a "reasonable belief" element.

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[6] The precedent coming closest to such a holding, *Mathews*, 87 F.3d at 635, analyzes conflicting expert testimony only under §§ 11112(a)(1) and (4). *Id.* at 636 n.9, 638. The *Mathews* court did not address the absence of a "reasonable belief" element in subsection 2. In holding that the defendants had met the requirements of subsection 2, the *Mathews* court relied on a review process which examined 208 cases, lasted over two years, and disclosed 23 instances of substandard care. *Id.* at 637, 630-31.

The Petitioners' argument rests on cases applying subsections 1 and 4 of § 11112(a), which both include a "reasonable belief" element. Petition at 13-15. The Tenth Circuit, however, concluded that the Petitioners were not entitled to immunity because the jury could reasonably have concluded that the hospital did not satisfy subsection 2 of § 11112(a), which does not consider the "reasonable belief" of the peer review participants. Instead, § 11112(a)(2) requires that the peer review action must be taken "after a reasonable effort to obtain the facts of the matter," with no allowance for the peer review participant's belief that the effort to obtain the facts was reasonable. App. 37.

Thus, the Petitioners disregard the difference between the language of subsections 1 and 4 and the language of subsection 2 in attempting to depict a split among the circuits. The language of subsection 2 forecloses the Petitioners' reliance on cases holding that HCQIA immunity is available if the defendant acted in the reasonable belief that the peer review action was proper, Petition 16, or unavailable only where the plaintiff shows that no reasonable reviewer could have believed the action was warranted. Petition 18-19.

The extremity of the Petitioners' argument deserves emphasis. If the Petitioners are correct, conflicting expert testimony is always insufficient, regardless of the circumstances, to create a fact issue under any of the § 11112(a) standards, with the possible exception of subsection 3, relating to notice and hearing. Other HCQIA decisions appear to foreclose reliance on evidence of subjective bad faith, malice or anticompetitive motives. *See, e.g., Bryan*, 33 F.3d at 1323; *Austin*, 979 F.2d at 734. The combined

effect of these decisions and the Petitioners' interpretation of § 11112(a) would be that a plaintiff facing a claim of HCQIA immunity could rebut the presumption of reasonableness only with evidence of inadequate notice or hearing. The Petitioners' position would therefore make HCQIA immunity essentially absolute, a result Congress clearly did not intend in creating qualified immunity based on a rebuttable presumption of reasonableness. *See, e.g., Summit Health, Ltd. v. Pinhas*, 500 U.S. 322, 332, n.12 (1991) (quoting legislative history of HCQIA stating that "[t]he immunity provisions [were] restricted so as not to protect illegitimate actions taken under the guise of furthering the quality of health care. Actions . . . that are really taken for anticompetitive purposes will not be protected under this bill."); App. 21, n.9.

Congress did not intend to grant absolute immunity to any defendant who hires an expert. The Petitioners, in attempting to make HCQIA immunity essentially absolute by importing the "reasonable belief" element into subsection 2, disregard the plain language of the statute. *See West Virginia University Hospitals, Inc. v. Casey*, 499 U.S. 83, 98 (1991) (text of the statute is the best evidence of Congressional intent). The effect the Petitioners argue for would require an amendment to the HCQIA. *See Patrick v. Burget*, 486 U.S. 94, 105, n.8 (1988) ("If physicians believe that the Act [HCQIA] provides insufficient immunity to protect the peer review process fully, they must take that matter up with Congress."). Under the plain language of subsection 2, Dr. Lindley's unrebutted conclusion that the hospital unreasonably restricted the scope of review in Dr. Brown's case by examining only two charts defeated HCQIA immunity.

II. The Tenth Circuit Correctly Found That A Reasonable Jury Could Have Concluded That Ms. Miller Knew Her Report To The National Practitioner Data Bank Was False.

The Petitioners do not claim that the Tenth Circuit's denial of HCQIA immunity to Ms. Miller under 42 U.S.C. § 11137(c)[7] creates a split among the circuits. Instead, the Petitioners seek review of the defamation verdict because they believe that the Tenth Circuit improperly applied § 11137(c) in holding that the evidence that Ms. Miller made the report with knowledge of its falsity was sufficient to overcome HCQIA immunity. Petition 23-26.

Again, the Petitioners' argument seeks certiorari to revisit a garden variety "substantial evidence" issue. The record in this case more than suffices to show that Ms. Miller knew of the falsity of her "Incompetence/Malpractice/Negligence" report. Neither the review panel nor the hospital's Board ever made a finding of incompetence, malpractice or negligence on Dr. Brown's part. App. 22. Ms. Miller knew no such finding had been made. App. 22. Ms. Perry, who assisted Ms. Miller in selecting the code designation for the report, told Ms. Miller that she was concerned about its accuracy. App. 38-39. When Dr. Brown disputed the report, the Data Bank gave the hospital the opportunity to revise the code designation, but the hospital declined. App. 39. Also, Ms. Miller received a copy of Mr. Lasater's letter distinguishing between standard of care issues and the issue presented in Dr. Brown's

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[7] Section 11137(c) states that "[n]o person . . . shall be liable . . . with respect to any report made under this subchapter . . . without knowledge of the falsity of the information contained in the report."

case concerning whether Dr. Brown had violated her consultation requirement. App. 39.

In view of this record, the Tenth Circuit's denial of § 11137(c) immunity accords with the plain meaning of the phrase "without knowledge of the falsity of the information contained in the report." Dr. Brown presented enough evidence to allow a reasonable jury to decide that Ms. Miller made a false report with knowledge of its falsity. The punitive damage award against Ms. Miller underscores the strength of the record revealing her improper motives.

CONCLUSION

The Court should deny the Petitioners' request for a writ of certiorari.

Respectfully submitted,

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In The

Supreme Court of the United States

October Term, 1996

VALERIE MILLER and VICKIE WILLIAMS, D.O.,

Petitioners,

vs.

ARLENE M. BROWN, M.D.,
and FAMILY PRACTICE ASSOCIATES, P.C.,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Tenth Circuit

PETITIONERS' REPLY BRIEF

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PETITIONERS' REPLY BRIEF

Dr. Brown advances two reasons why a writ of certiorari should not be granted on the first question presented, regarding the standard to be applied to the "reasonableness" criteria of section 11112(a) of the HCQIA. First, she contends that the Tenth Circuit merely "resolved an ordinary 'substantial evidence' issue." (Brief in Opp., p. 2.) Second, she contends that this case is limited to its facts and does not present an inter-Circuit conflict because the Tenth Circuit based its decision on the "reasonable effort to obtain the facts" requirement of subsection 11112(a)(2). (*Id.* pp. 1-2.) Neither reason should deter this Court from granting the writ.

Whether there was substantial evidence to support a denial of immunity depends, of course, on what standard applies to assertions of immunity under the HCQIA. Under the objective standard adopted by the Third, Fourth, Ninth, and Eleventh Circuits, the statutory presumption of immunity is not called into question by a disagreement among experts regarding the reasonableness of a review action when there is no dispute that a reasonable reviewer could have decided that the action was warranted. Under the Tenth Circuit's approach, a difference among experts is sufficient to permit a jury to reexamine the medical judgments of peer reviewers and award damages if it disagrees with the reviewers' determinations. In deciding on the sufficiency of the evidence, the Tenth Circuit expressly rejected the objective reasonableness standard as applied in the other Circuits. (App. 20-21 n.9.)

This critical issue is cast in sharp focus by the record. Dr. Lindley's opinion regarding the hospital's reliance on two cases was far from "unrebutted." (Brief in Opp., pp. 4, 8, 11.) Both defense experts testified that the restriction of Dr. Brown's privileges was justified by the cases considered by the peer reviewers. The record thus reflects conflicting opinions as to whether the hospital's fact-finding effort was reasonable. What *is* unrebutted, however, is that a reasonable physician *could* find that the risk to Dr. Brown's patients, as evidenced by the two cases reviewed, was sufficiently serious to warrant restriction of Dr. Brown's hospital privileges.[1] Whether that showing is sufficient to qualify for HCQIA immunity as a matter of law is the first of the questions presented by this case.

That question properly calls for review of the standard applicable to all three "reasonableness" criteria of section 11112(a) – the subsection 11112(a)(2) "reasonable effort" requirement as well as the "reasonable belief" provisions of subsections 11112(a)(1) and (a)(4). No court has drawn a distinction between the standard applicable to "reasonable effort" and that applicable to "reasonable belief." Nor is there a principled basis for doing so. (Pet.,

---

[1] It is a distortion of the record to characterize the cases reviewed as instances in which the hospital "recognized" or admitted (Brief in Opp., pp. 2, 6) that Dr. Brown did not violate the standard of care. Because the hospital's concern was with potential harm to patients, whether Dr. Brown breached the standard in those cases was immaterial. Even Dr. Brown cannot be contending that a hospital must wait until a physician actually commits malpractice before it can act to protect patients from a foreseeable risk of injury without jeopardizing its ability to obtain immunity under the HCQIA.

pp. 19-20.) All three "reasonableness" criteria are implicated in this case, and the Tenth Circuit did not distinguish one of them from the other in its decision broadly rejecting an objective standard for HCQIA immunity. (App. 20-21 n.9.)[2] In deciding claims of HCQIA immunity, other courts have necessarily considered the "reasonable effort" requirement either under subsection 11112(a)(2) or as an element of subsection 11112(a)(4). Except for the Tenth Circuit, no court has failed to accept the judgment of medical reviewers who had an objectively reasonable basis for concluding that a review action was warranted in light of the risk revealed by the particular cases reviewed. (Pet., pp. 20-21.) The Tenth Circuit's decision is in direct conflict with four other Circuits that have considered the section 11112(a) criteria.[3]

Dr. Brown argues that the second question presented by this case, relating to the immunity for Data Bank reporting provided by HCQIA section 11137(c), also involves only a "substantial evidence" issue. (Brief in Opp., p. 12.) Again the sufficiency of the evidence depends on a prior determination of the applicable standard. Under a proper standard, the hospital's report to

---

[2] Dr. Brown appears to recognize that the Tenth Circuit's analysis is equally applicable to all three of these criteria. (*See* Brief in Opp., pp. 8-9.)

[3] An objective standard does not lead to the "absolute" immunity for medical peer reviewers projected by Dr. Brown and the Tenth Circuit. (Brief in Opp., p. 11; App. 21; *see* Pet., pp. 18-19.) It does, however, provide limited immunity from damages when a review action bears the hallmarks of legitimacy that would satisfy a standard of objective reasonableness.

the Data Bank in language accurate on its face cannot be "false" and hence should be immunized as a matter of law. The question is properly joined with the question arising under section 11112(a) because, in both instances, the Tenth Circuit has misapprehended the Congressional intent underlying the HCQIA and has adopted standards for immunity that are unduly restrictive and will frustrate the vital purpose that Congress sought to achieve through this statute. There is a compelling need to reach both questions presented by the Petition.

A writ of certiorari should therefore be granted.

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IN THE

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OCTOBER TERM, 1996

VALERIE MILLER, *et al.*,
Petitioners,

v.

ARLENE M. BROWN, M.D., *et al.*,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit

MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* AND BRIEF *AMICUS CURIAE* OF THE AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF PETITIONERS

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MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE*

The American Hospital Association hereby respectfully moves for leave to file the attached brief *amicus curiae* in support of petitioners in the above-styled case. Counsel for petitioners have consented to the filing of the brief. The consent of counsel for the respondents was requested but refused.

The American Hospital Association is the primary organization of hospitals in the United States. Its membership includes 70% of the Nation's 5,000 hospitals, health systems, and other health care institutions, as well as approximately 38,000 personal members. The Association has a vital interest in the interpretation of the Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101 *et seq.* ("HCQIA") that is at issue in this peti-

tion. HCQIA's provisions protecting "peer review" proceedings are critical to the ability of the Association's member hospitals to ensure quality health care for their patients.

The American Hospital Association serves a nationwide constituency of interested hospitals and health care providers. The Association has closely monitored judicial interpretations of HCQIA and participated as *amicus curiae* in a number of cases. Accordingly, the American Hospital Association respectfully submits that it is able to offer a broader perspective on the nationally important issues raised by the petition than can be provided by the parties alone.

WHEREFORE, the American Hospital Association respectfully requests that the Court grant leave for the filing of the attached brief *amicus curiae*.

Respectfully submitted.

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---

BRIEF *AMICUS CURIAE* OF THE AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF PETITIONERS

STATEMENT OF INTEREST OF THE *AMICUS CURIAE*

The American Hospital Association ("AHA") is the primary organization of hospitals in the United States. The AHA's mission is to advance the health of individuals and communities. AHA leads, represents, and serves health care provider organizations that are accountable to the community and committed to health improvement. Its membership includes 70% of the Nation's 5,000 hospitals, health systems, and other providers of care. Over 38,000 health care professionals hold individual memberships in the AHA. Through participation here, AHA seeks to further the "overriding national need" for effective physician

peer review expressed by the Congress in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101 *et seq.* ("HCQIA").

Peer review is a vital means by which hospitals can protect patients from physicians who are incompetent or who engage in unprofessional behavior. Effective peer review can be jeopardized by the threat of retaliatory litigation brought by physicians whose clinical privileges or staff memberships have been adversely affected. HCQIA is intended to reduce this risk by providing peer review participants with immunity from suits for money damages. By promoting effective peer review and instituting a reporting system for peer review actions, HCQIA is intended to protect patient health and safety nationwide.

AHA's hospital and health care provider members share a keen interest in ensuring that judicial construction of HCQIA takes into account the importance to patients of peer review and the crucial role HCQIA's immunity plays in encouraging successful peer review. Congress recognized in adopting HCQIA that the practice of incompetent physicians cannot be curtailed unless those willing to participate in peer review are protected by immunity from the threat of resulting litigation. Judicial construction of the statute that undermines this protection is therefore a matter of grave concern to the AHA and its members.

SUMMARY OF ARGUMENT

The peer review immunity provisions of HCQIA are vital to the safety of patients nationwide. Only effective immunity can provide physicians—who alone possess the skills to evaluate their peers—with the protection that allows them to participate in peer review. Only peer review allows HCQIA's national reporting system to prevent the continued practice of incompetent or unprofessional physicians. In short, Congress recognized in passing HCQIA that peer review immunity is an important keystone on which quality health care depends.

Achievement of HCQIA's purposes requires faithful judicial application of the objective standard of review and the presumption in favor of immunity provided by the statute. This means that a plaintiff should not be able to subject peer reviewers to a jury trial for money damages unless the plaintiff has produced affirmative evidence that would allow a jury to determine that no reasonable peer reviewer could have reached the conclusion at issue in the "reasonable belief that the [action] was warranted by the facts known after a reasonable effort to obtain facts." *Austin v. McNamara*, 979 F.2d 728, 735 (9th Cir. 1992).

In conflict with other courts of appeals that have addressed HCQIA's immunity provisions to date, the court below rejected the principle that peer reviewers are entitled to immunity as a matter of law where the record establishes that the action taken was among those that a reasonable peer reviewer could have taken, without regard to whether the court or jury might itself have reached a different conclusion. The opinion below instead endorses an approach that subjects peer reviewers to the risk that juries will second-guess their medical judgments in damages suits, directly contrary to congressional intent. The chilling effect on peer review created by this approach threatens a degree of harm to national health care safety that merits the Court's attention.

The second important aspect of the court of appeals' opinion—affirming a judgment for defamation based upon the completion of a box with a code number on the standard form for reporting adverse action to the National Practitioner Data Bank—also presents a serious threat to the national system for protecting patient safety that HCQIA created. Peer reviewers are *required* to report certain adverse actions to the National Practitioner Data Bank, and required to do so on a standard form. Here the court below allowed imposition of *damages based upon the selection* of a reporting category that was plainly a reasonable choice under the circum-

stances. The decision below is irreconcilable with this Court's understanding of the meaning of "knowing falsity," the applicable standard for immunity under HCQIA. The Court's attention is warranted to protect the vitality of our national health care safety information system.

ARGUMENT

I. HCQIA'S IMMUNITY AND REPORTING PROVISIONS ARE VITAL TO PROTECTING PUBLIC HEALTH THROUGH VIGOROUS PEER REVIEW

The foundation of HCQIA's protection of patient health and safety is the system of "medical peer review." Peer review involves "setting standards of care, reviewing cases to determine whether the standards are being met, recommending and implementing methods to improve substandard care, and subsequent reviews of care to determine whether goals have been achieved." *See* Southwick & Slee, *Quality Assurance in Health Care: Confidentiality of Information and Immunity for Participants*, 5 J. Legal Med. 343, 346 (1984). It is through the constant scrutiny of the peer review process that patients are protected from substandard care through the imposition of monitoring and consultation requirements or, ultimately, through formal disciplinary action such as a reduction, suspension, or termination of clinical privileges or staff membership.

Effective peer review is not only a vital aspect of every hospital's ethical duty to protect the public health; it is a legal necessity. Hospitals are bound by law to ensure that only qualified physicians are allowed to treat patients. *See, e.g., Darling v. Charleston Community Memorial Hosp.*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966) (the seminal opinion on hospital "corporate negligence"). State laws and regulations may also impose peer review requirements directly. *See, e.g.*, Cal. Code Regs. tit. 22 § 70703. In addition, peer review procedures are mandated by national accrediting bodies such as the Joint Commission on the Accredita-

tion of Healthcare Organizations (JCAHO). *See* JCAHO, Comprehensive Accreditation Manual for Hospitals; The Official Handbook (1/1/97), Ms. 2.3.3, Ms. 5.7, Ms. 5.8. In short, medical ethics, state law, and the Nation's major hospital accrediting authority all make peer review essential to delivering quality health care.

Physicians' voluntary service in peer review programs is indispensable to protecting the quality of care, for only physicians possess the "particular skills and judgment" necessary for assessing and analyzing the quality of care rendered in a hospital. See American Hospital Association/American Medical Association, *Report of the Joint Task Force on Hospital-Medical Staff Relationships* II (1985). Unfortunately, doctors know that one likely consequence of participation on peer review committees is the threat of litigation. Litigation—especially antitrust litigation, with its potential for complexity, high litigation costs, and treble damages—is a fearsome disincentive to service as a peer reviewer. *See* 42 U.S.C. § 11101 (finding of Congress). Without HCQIA immunity none but the most resolute physicians would agree to participate in peer review.[1]

With the passage of HCQIA, Congress moved to bolster peer review systems and to address shortcomings

[1] Sanctioned physicians often retaliate against their peer reviewers with a legal blunderbuss. Possible causes of action include defamation, antitrust, discrimination, malpractice, due process, equal protection, breach of contract, tortious interference with contractual or business relationships, intentional infliction of emotional distress, and claims under the Racketeer Influenced and Corrupt Organizations Act ("RICO"). *See* Peer Review Immunity Task Group of the American Academy of Hospital Attorneys of the American Hospital Association, *Immunity For Peer Review Participants in Hospitals: What Is It? Where Does It Come From? How Do You Protect It?* 72-75 (1989). Physicians themselves are well aware that this type of litigation is usually complex, expensive, and hard fought. *See* Curran, *Law-Medicine Notes: Medical Peer Review of Physician Competence and Performance: Legal Immunity and the Antitrust Laws*, 316 New Eng. J. Med. 597 (1987).

that required national solutions. Prior to the passage of HCQIA, reporting of physician incompetence was the province of state licensing boards. Unfortunately, both the definition of offenses and the standards for dealing with them varied from state to state. *See, e.g., Medical Malpractice: Hearings on H.R. 5110 Before the Subcommittee on Health and the Environment of the House Committee on Energy and Commerce*, 99th Cong., 2d Sess. 308 (1986) (statement by Richard P. Kusserow, Inspector General, Department of Health and Human Services). Because state licensing and reporting systems were not centralized and uniform information was not available, incompetent physicians could move easily from state to state, often "plea bargaining" an arrangement allowing them to resign staff privileges or credentials and depart before formal hospital or state licensure action was taken. *See* H.R. Rep. No. 903, 99th Cong., 2d Sess. 2-3 *reprinted in* 1986 U.S. Code Cong. & Admin. News 6385.

HCQIA was passed to address these problems. It does so not only by protecting the physicians involved in peer review, but also by establishing "a comprehensive, nationwide system to prevent physicians who have been identified as incompetent by one hospital from simply relocating and resuming their practice in another." Note, *The Health Care Quality Improvement Act of 1986: Will Physicians Find Peer Review More Inviting?*, 74 Va. L. Rev. 1115, 1125-26 (1988). HCQIA accomplishes this through the operation of the National Practitioner Data Bank ("NPDB" or "Data Bank"). Hospitals, as well as insurers and other health care entities and state boards of medical examiners, are required to report adverse credentialing actions and medical malpractice payments to the Data Bank. *See* 45 C.F.R. Part 60. They are required to use a standard form for making reports. 42 U.S.C. § 11134; 45 C.F.R. § 60.4; Health Resources & Services Admin., U.S. Dept. of Health & Human Servs., *National Practitioner's Data Bank Guidebook* (1996), Section E and Appendix A [hereinafter "*Guidebook*"]. Hospitals or

health care entities that fail to follow the reporting requirements of HCQIA may lose their immunity for three years. 42 U.S.C. § 11133(c). Hospitals are required to request information from the Data Bank when they receive an application for privileges. 42 U.S.C. § 11135. Thus, reported problems a physician has at one hospital will be known to any other hospital where he or she applies for privileges. The importance of this system to the public health is self-evident. But it cannot function without physician participation in peer review and hospital support.

HCQIA reflects Congress' recognition that peer reviewers' fears of protracted and expensive lawsuits by disgruntled physicians could jeopardize national health care safety. Congress set forth the following reasons for enacting HCQIA:

> (1) The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual state.
>
> (2) There is a national need to restrict the ability of incompetent physicians to move from state to state without disclosure or discovery of the physician's previous damaging or incompetent performance.
>
> (3) This nationwide problem can be remedied through effective professional peer review.
>
> (4) The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review.
>
> (5) There is an *overriding national need* to provide incentive and protection for physicians engaging in effective professional peer review.

42 U.S.C. § 11101 (emphasis added). By setting forth these reasons, Congress confirmed the "national need" to provide incentives and protection for peer reviewers.

HCQIA's immunity provision, 42 U.S.C. §§ 11111-11115, grant peer reviewers immunity from damages under both federal and state law where peer review actions are taken:

> (1) In the reasonable belief that the action was in the furtherance of quality health care,
>
> (2) After a reasonable effort to obtain the facts of the matter,
>
> (3) After adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances,[2] and
>
> (4) In the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph 3.

42 U.S.C. § 11112(a).[3]

HCQIA explicitly provides that its immunity provisions are *presumed* to apply where peer reviewers assert them. By imposing an *objective* standard by which to judge claims of qualified immunity and by imposing a presumption that the immunity applies, Congress codified its intent that HCQIA claims be resolved as a matter of law.

---

[2] HCQIA provides a list of procedural measures which, if followed, will be *deemed* to show compliance with this third immunity standard. The failure of an institution to employ all of these measures does not, however, deprive the hospital of immunity. *See* 42 U.S.C. § 11112(b) (last sentence). In addition, HCQIA explicitly provides for *immediate* suspension or restriction of privileges, without prior notice and hearing, "where the failure to take such an action may result in an imminent danger to the health of any individual." 42 U.S.C. § 11112(c)(2) (emphasis added).

[3] HCQIA immunity is limited to private damages actions, and does not prevent suits by federal or state governments under the Clayton Act or other provisions. HCQIA immunity is also inapplicable to civil rights suits, and raises no bar to plaintiffs seeking injunctive relief or declaratory judgments. 42 U.S.C. § 11111(a)(1).

Originally, Congress considered a subjective "good faith" standard, which would have required evidence of the defendant's subjective state of mind, an inquiry that could only be resolved by a jury. But this subjective standard was changed to the objective, "reasonable belief" test, which inquires into what the reviewers would reasonably have concluded, and not why they so concluded. H.R. Rep. No. 903, 99th Cong. 2d Sess. 10, *reprinted in* 1986 U.S. Code Cong. & Admin. News 6394. By setting this objective standard, and by allowing judges to rule on the presumption of immunity as a matter of law, Congress intended prompt, uniform, and early judicial disposition of HCQIA cases. *See* Comment, *The Health Care Quality Improvement Act of 1986: A Proposal for Interpretation of Its Protection*, 20 St. Mary's L.J. 955, 976 (1989).

II. THE DECISION BELOW CREATES A SPLIT OF AUTHORITY THAT THREATENS TO UNDERMINE PEER REVIEW AND PATIENT SAFETY

Prior to the decision below, courts have recognized that evaluation of HCQIA immunity does not involve a post hoc review with 20/20 hindsight, asking whether the action taken was "correct" or was the "best" course available. As the Ninth Circuit stressed in *Austin v. McNamara*, 979 F.2d 729 (9th Cir. 1992), there may frequently be evidence that might "call into question the ultimate reasonableness" of the action taken against a physician. *Id.* at 735. *But*, as that Court aptly put it: "That is a different question of 'reasonableness,' however, than the issue whether the defendants acted in the 'reasonable belief that the [suspension] was warranted by the facts known after reasonable effort to obtain facts' as required by Section 11112(a)(4)." *Id.* Other courts of appeals have similarly applied HCQIA's objective standard with due regard for the presumption of immunity. *See Mathews v. Lancaster General Hosp.*, 87 F.2d 624, 635 (3d Cir. 1996); *Imperial v. Suburban Hosp. Ass'n*, 37 F.3d 1026, 1030 (4th Cir. 1994); *Bryan v. James E.*

Holmes Regional Medical Center, 33 F.3d 1318, 1323 (11th Cir. 1994), *cert. denied*, 115 S. Ct. 1363 (1995).

The facts and holding in *Austin* could hardly provide a starker contrast to the unfortunate holding below. Following the suspension of the plaintiff's privileges in *Austin*, the hospital's own Judicial Review Committee ("JRC") explicitly announced its disagreement with the decision and recommended that privileges be restored, stating that "the preponderance of the evidence favors Dr. Austin and . . . [that] the recommendation of the Medical Executive Committee was not reasonable and warranted and that the clinical privileges of Dr. Austin should not be revoked." *Id.* at 735. Notwithstanding this evidence, the Ninth Circuit concluded following a review of the entire JRC report that "no reasonable jury could find that the JRC report is sufficient to establish the nonexistence of defendants' 'reasonable belief' and 'reasonable effort' " under HCQIA standards. *Id.* at 735.

The Ninth Circuit's opinion in *Austin* is impossible to reconcile with the decision below. Here the respondent physician herself acknowledged that the conclusion reached by the peer reviewers was "one conclusion that could have been reached, but not the only one." Pet. 10. Notwithstanding this evidence, the Tenth Circuit upheld a jury damages verdict based solely upon the testimony of respondents' expert, Dr. Lindley. App. 20. The Tenth Circuit was quite explicit in rejecting the approach that had mandated entry of judgment for the defendants in *Austin*:

> According to the defendants, a "difference of opinion among experts" does not raise an issue as to the objective reasonableness of the inquiry. We are not persuaded by the defendant's view.

App. 20 at n.9. The approach adopted by the court below is in fact the approach advocated by the *dissent* in *Austin*, in which the jury is called upon to choose among

competing medical conclusions. *See* 979 F.2d at 741-42 (Pregerson, J., dissenting).

Contrary to the erroneous suggestion raised by respondents, Opp. 9, the severity of the circuit split created by the erroneous decision below cannot be lessened by characterizing it as a decision about a "separate" statutory standard relating to the "reasonable effort" to gather facts called for by 42 U.S.C. § 11112(a)(2). The court of appeals plainly did not distinguish among HCQIA's "reasonableness" standards in rejecting the objective approach of the other circuits. *See* App. 20 n.9. There is no basis upon which the court could have done so, for operation of this presumption applies in the same manner to *all four* statutory standards.

As originally proposed, the HCQIA presumption was to apply only to the first standard listed in 42 U.S.C. 11112(a), *i.e.*, that the professional review action was taken in the furtherance of quality health care. But Congress emphasized its desire for early resolution of immunity claims by changing the statute to apply the presumption to all four standards:

> *All four standards are now treated similarly.* The standard concerning whether the action was in furtherance of the quality of care still has the benefit of a presumption, but now that presumption is to be overcome by a preponderance of the evidence. *Similarly, the amendment now makes clear that the burden of proof with respect to the other three standards is the same as that for subsection 102(a)(1) and rests on the plaintiff*, not the defendant or defendants.

132 Cong. Rec. H9954, H9959 (daily ed. Oct. 14, 1986) (statement of Rep. Waxman) (emphasis added). In practical application, the standards in fact become part of the same inquiry. Contrary to respondents' statement that no prior decision dealt with the "reasonable effort" standard, the *Austin* court described the relevant question as whether the action taken was "warranted by the facts

known *after reasonable effort to obtain the facts.*" 979 F.2d 728 (emphasis added). So too, here, the ultimate conclusion of the doctors who testified that the peer reviewers' actions were reasonable obviously included the subsidiary conclusion that they were based upon adequate facts.

Subjecting peer reviewers to second-guessing by juries based upon the argument that more medical records should have been reviewed is particularly pernicious. Any lawyer with experience in peer review cases will recognize the hackneyed argument that—notwithstanding the errors in a specific case—a physician can only be judged fairly if a much larger body of work is reviewed. In the complex context of peer review, the argument is a particularly dangerous one, for it raises endless questions over how many records to review and how to select them. HCQIA was meant to relieve doctors from the threat that peer review will leave them open to liability unless they make choices with which no other expert will disagree or engage in a time consuming review of the subject doctors' life's work entailing endless hours away from the reviewers' own medical duties. *See Fobbs v. Holy Cross Health System Corp.*, 789 F. Supp. 1054, 1066 (E.D. Cal. 1992), *aff'd in relevant part*, 29 F.3d 1439 (9th Cir. 1994) (rejecting claim that "the number of cases initially investigated and upon which the monitoring restraints were imposed, four, was too small"). Yet this is exactly the threat to peer review given judicial endorsement by the decision below.

This Court should grant certiorari and give clear guidance that HCQIA's objective standard affords immunity unless *no physician* would reasonably believe from the facts that he or she was acting in furtherance of quality health care or that the action taken was warranted by the facts. Under a proper application of the objective standard as interpreted by the Third, Fourth, Ninth, and Eleventh Circuits, the fact that there is often more than one manner in which to handle a particular peer review situa-

tion provides no basis for concluding an action is unreasonable. Contrary to the suggestion of respondents and the court below, this would not amount to "absolute immunity" for peer reviewers, but instead would reflect a proper application of qualified immunity standards with which the Court has long been familiar in other contexts. Cf. *Malley v. Briggs*, 475 U.S. 335, 341 (1986) (to be effective, qualified immunity must protect decisions over which decisionmakers "of reasonable competence could disagree").

III. THE TENTH CIRCUIT'S DECISION REPRESENTS A SERIOUS THREAT TO THE NATIONAL DATA BANK THAT MERITS THE COURT'S ATTENTION

The second aspect of the decision below—affirmance of a judgment for defamation based upon the completion of a box with a code number on the standard National Practitioner Data Bank reporting form—presents an equally serious threat to the system of medical safety information created by HCQIA. HCQIA requires health care entities to report the actions of peer reviewers to the National Practitioner Data Bank. Moreover, the applicable requirements specify the form upon which such a report must be made and require a health care entity employee to choose from among numbered codes to classify the peer review action taken. *See Guidebook*, Appendix A (*see also*, Adverse Action Report Forms and Instructions).

In this case, the available choices on the reporting form were as follows:

Revocation—Clinical Privileges

610.01 Alcohol and Other Substance Abuse
610.02 Incompetence/Malpractice/Negligence
610.03 Narcotics Violations
610.04 Felony
610.10 Unprofessional Conduct
610.20 Medical Disorder
610.30 Allowing Unlicensed Persons to Practice

610.50 Disciplinary Action Taken in Another State
610.80 Physical Impairment
610.90 Other

Pls. Ex. 62. In the circumstances presented here—failure to obtain a required consultation before treating a type of patient whom the physician had agreed not to treat without consultation because of questions raised about her competence to do so—petitioners chose classification number 610.02, "Incompetence/Malpractice/Negligence."

As the court below acknowledged, HCQIA precludes liability based upon the filing of a Data Bank adverse action report "unless there is sufficient evidence for a jury to conclude the report was false and the reporting party knew it was false." App. 21, *citing* 42 U.S.C. § 11137(c). The court below subjected the hospital's employee here to damages liability based upon a highly formalistic analysis: because the peer review committee had never issued a formal judgment of "incompetence/malpractice/negligence," (*i.e.*, in just those words) it was therefore "knowingly false" for defendants to select this code number on the standard reporting form. App. 22. Unless corrected by this Court, this hypertechnical approach to liability for Data Bank reporting will severely chill the willingness of hospital employees to submit the reports upon which the Data Bank is built.

The choice of classification 610.02 was plainly a reasonable alternative under any fair understanding of the "knowing falsity" standard. As the court of appeals acknowledged, the peer reviewers here had concluded that the respondent physician was competent to handle *low risk* obstetrical patients, but had exacted a promise from her due to concerns about her competence that she would not treat high risk obstetrical patients without obtaining a consultation. App. 4, 22. Notwithstanding her promise made following questions about her competence to care for high risk obstetric patients without a consult, respondent did just that—she treated high risk patients without obtaining the consultation as agreed. In other words, re-

spondent treated patients without consultation whom she had agreed at the hospital's insistence not to treat without a consultation due to questions about her competence to do so. In this situation, the selection of a classification of "Incompetence/Malpractice/Negligence" surely cannot be described as a "knowingly false" choice. At most, it reflects a debatable choice among available alternatives to describe an ambiguous situation.

Moreover, in filling out the report form, the hospital's employee gave a clear and accurate description of the basis for the action taken: "failure to obtain mandatory consults on high risk obstetrics." Pl. Ex. 62. Given the choices available upon the standard reporting form and the fact that the hospital employee gave a full and accurate description of the basis for the action, it is difficult to imagine what more she was supposed to have done. It is a truism of defamation litigation that a statement must be viewed in context as a whole. Here, however, the Tenth Circuit affirmed a judgment for defamation under HCQIA's more protective standards based upon a form that was undeniably accurate.[4]

The standard upon which the court purported to uphold liability against the defendants—"knowing falsity"—is one that this Court in other defamation contexts has found to give a high degree of protection to speakers. For example, in *Time, Inc. v. Pape*, 401 U.S. 279 (1971), the Court held that actual malice—which requires the *lesser* showing of knowledge of falsity *or* recklessness as to falsity—could not be shown from the omission of the word "alleged" in

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[4] Imposition of liability for defamation was particularly improper here, where respondent had failed to pursue her administrative remedies to have the Report reviewed for accuracy by the Secretary of Health and Human Services. *See* 45 C.F.R. § 60.14. One Court has in fact held that subject matter jurisdiction over a claim based upon Data Bank reporting is lacking where the plaintiff has not exhausted the administrative remedies provided by HCQIA. *See Bigman v. Medical Liability Mutual Insurance Co.*, 1996 WL 79330 (S.D.N.Y. February 22, 1996).

reporting charges of police brutality. While the omission could be said to make the statement at issue false in a technical sense, the omission

> amounted to the adoption of one of a number of possible rational interpretations of a document that bristled with ambiguities. The deliberate choice of such an interpretation, though arguably reflecting a misconception, was not enough to create a jury issue of "malice" under *New York Times.*

Id. at 289-90.

Similarly, in *Bose Corp. v. Consumers Union of U.S., Inc.*, 466 U.S. 485 (1984), the defendant reviewer was sued for product defamation. He had written that instruments heard through the plaintiff's loudspeakers appeared to "move about the room." The defendant conceded, however, that in fact he had observed the sounds moved "along the wall"—not "about the room"—a significant difference for purposes of evaluating a loudspeaker. This Court affirmed the court of appeals' entry of judgment in favor of the defendant on the ground that the burden of showing knowledge of falsity had not been met:

> The trial court took him at his word, and reasoned that since he did know what he had heard, he must have realized the statement was inaccurate at the time he wrote it. "Analysis of this kind may be adequate when the alleged libel purports to be an eyewitness or other direct account *of events that speak for themselves.*" *Time, Inc. v. Pape*, 401 U.S., at 285. See generally *The Santisima Trinidad*, 7 Wheat. 283, 338-339 (1822). Here, however, adoption of the language chosen was "one of a number of possible rational interpretations" of an event "that bristled with ambiguities" and descriptive challenges for the writer. *Time v. Pape, supra*, at 290. The choice of such language, though reflecting a misconception, does not place the speech beyond the outer limits of the First Amendment's broad protective umbrella.

Id. at 512-13.

The "broad protective umbrella" of the actual malice standard that the Court addressed in *Bose* is in fact *less protective* than the strict "knowing falsity" standard Congress adopted in HCQIA to protect hospital employees who must assign a Data Bank reporting description to complicated events that necessarily "bristle with ambiguities." Here, however, the court below applied a crabbed reading of HCQIA that deprived the individual completing the report of the protection to which she was entitled. Affirmance of a judgment for defamation in these circumstances represents a serious threat to the willingness of all involved to participate in reporting to the National Practitioner Data Bank. Given the clear conflict of this decision with this Court's prior interpretations of "knowing falsity" and the potential consequences for health care safety, review by the Court is warranted.

CONCLUSION

For the foregoing reasons, *amicus* AHA respectfully submits that the petition should be granted.

Respectfully submitted,

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